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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03222

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WHEATON
d. STREET ADDRESS: 2322 BLUERIDGE AVE
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First / Middle / Last: CHARLES BARNES ABBOTT JR.

4. DATE OF DEATH: Month: AUGUST Day: 20 Year: 1961

5. SEX: M ALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: OCT. 24 1897

9. AGE (In years last birthday): 63 ~~68~~ yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: CHARLES BARNES ABBOTT SR.

14. MOTHER'S MAIDEN NAME: CARRIE RUSSELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): NAVY WORLD WAR I

16. SOCIAL SECURITY NO.: 578-03-8912

17. INFORMANT: Wife Eliz. Jane Abbott (Same as above)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous heart disease

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J Brochart M.D.
EXAMINER'S NAME (Type): FRANK J. BROCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 8-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify): XXXXXX Burial

22b. DATE THEREOF: 8/23/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or country) (State): Arlington County Virginia

23. FUNERAL DIRECTOR: Raymond A. Ziska
ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
Warner E. Pumphrey, Inc.

24a. REC'D BY REGISTRAR DATE: AUG 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

[redacted]

[redacted]

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9233 **CERTIFICATE OF DEATH** 09223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase 55
d. STREET ADDRESS: 4704 Morgan Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: S — Last: Adams

4. DATE OF DEATH: Month: August — Day: 28 — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 24, 1902
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Writer
10b. KIND OF BUSINESS OR INDUSTRY: Associated Press
11. BIRTHPLACE (County & State, or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dr. Thomas S. Adams
14. MOTHER'S MAIDEN NAME: Helen Wilkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 429-09-8079
17. INFORMANT: (Wife) Mrs. Amanda Adams — Address: As above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 12 days
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from AUG 12, 1961, to AUG. 28, 1961, that (I) (we) last saw the deceased alive on AUG 28 1961, and that death occured at 5:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Leo M. Curtis M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-28-61
22c. PHYSICIAN'S NAME (Type): Leo M. Curtis
22d. ADDRESS: 8218 Wisconsin Ave. Bethesda, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Trans
23b. DATE THEREOF: 9/1/61
23c. NAME OF CEMETERY OR CREMATORY: Roselawn Cemetery
23d. LOCATION (City, town or county) (State): Baton Rouge, Louisiana

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. RECD BY REGISTRAR DATE: AUG 30 61
25b. REGISTRAR'S SIGNATURE: C. Thos S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9234 **CERTIFICATE OF DEATH** 09224

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 52 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2024 Powhatan Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Marlowe — Last: Ager
4. DATE OF DEATH: Month: August — Day: 8 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 23, 1886
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles B. Ager
14. MOTHER'S MAIDEN NAME: India Marlowe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 577-30-7570
17. INFORMANT: J. Norman Ager — Address: 6100 Ager Road, Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 20 min
DUE TO
(b) Acute myocardial infarct — 2 hrs
DUE TO
(c) Coronary Atherosclerosis — Several years

420 ✓1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 9, 1961 to July 25, 1961, that (I) (we) last saw the deceased alive on Aug 7 1961 and that death occured at 4:08 AM from the causes and on the date stated above.

22a. SIGNATURE: Raymond O. West M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): RAYMOND O. WEST
22d. ADDRESS: WASHINGTON SANITARIUM

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Aug. 11, 1961
23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
23d. LOCATION (City, town or county): WASHINGTON (State): D.C.
24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: 254 CARROLL ST NW, D.C.
25a. REC'D BY REGISTRAR — DATE: AUG 10 '61
25b. REGISTRAR'S SIGNATURE: Clarence S. Greene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9235 **CERTIFICATE OF DEATH** 09225

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 050

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 63 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
d. STREET ADDRESS: P. O. Box 15
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: BUSH; Middle: (none); Last: AINSWORTH

4. DATE OF DEATH: Month: August; Day: 30; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: February 24, 1897

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Farming-Carpentry

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James M. Ainsworth

14. MOTHER'S MAIDEN NAME: Margaret E. Wiley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): yes-WWI

16. SOCIAL SECURITY NO.: 216-18-0041 ~~Not available~~

17. INFORMANT (Name, address): The Medical Record, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Histoplasmosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
1. Staphylococcal Septicemia 2. Pulmonary tuberculosis; active

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 28, 1961, to August 30, 1961 that (I) (we) last saw the deceased alive on August 30, 1961, and that death occured at 12:20 p.m. from the causes and on the date stated above.

22a. SIGNATURE William T. Butler M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [X]

22b. DATE SIGNED: 8/30/61

22c. PHYSICIAN'S NAME (Type): William T. Butler, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-2-61

23c. NAME OF CEMETERY OR CREMATORY: Laytonsville

23d. LOCATION (City, town or county) (State): Laytonsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber

ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9236 **CERTIFICATE OF DEATH** 09226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 506 Gilmoure Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: SALLIE Middle: LEE Last: ALLMAN

4. **DATE OF DEATH**: Month: August Day: 10 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1883
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cigar Rolling Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathaniel Thomas Allman
14. MOTHER'S MAIDEN NAME: Annie Wrenn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No
16. SOCIAL SECURITY NO.: 223-10-1224
17. **INFORMANT** (Wellford Harrison) nephew-9404 Corsica Dr. Address: Beth, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 hours.
420.1
DUE TO (b) Coronary Thrombosis — " "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Coronary Atherosclerosis — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9 Aug, 1961, to 10 Aug, 1961, that (I) (~~we~~) last saw the deceased alive on 10 Aug 1961, and that death occured at 7:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Seruch T. Kimble, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10 Aug '61.
22c. PHYSICIAN'S NAME (Type): Seruch T. Kimble
22d. ADDRESS: 927 Pershing Drive, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 14, 1961
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Montgomery County, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
WARNER E. PUMPHREY, INC., SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE [illegible] 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Krantz

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9237 04227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Maryland~~ D.C. b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2916 Northhamption St. N. W.
d. STREET ADDRESS: Washington, D. C. 47x3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadie Middle: Last: Alster
4. DATE OF DEATH: Month: August Day: 28 Year: 1961
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 15/1886
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Michael Trotsky, Russia
14. MOTHER'S MAIDEN NAME: Rose Trotsky, Russia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service):
16. SOCIAL SECURITY NO.: 558-36-3241A ~~unknown~~
17. INFORMANT: Carl J. Alster Address: (see 2c & 2d)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchogenic Ca — INTERVAL BETWEEN ONSET AND DEATH: 4 MOS
162.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAY, 1961, to AUG 28, 1961, that (I) (we) last saw the deceased alive on AUG 4, 1961, and that death occured at 6:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Bernard H Ostrow M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): BERNARD H. OSTROW
22d. ADDRESS: 8107 EASTERN AVE SS md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/30/61
23c. NAME OF CEMETERY OR CREMATORY: B'nai Abraham - Zion Cem.
23d. LOCATION (City, town or county) (State): Chicago, Ill.

24. FUNERAL DIRECTOR'S SIGNATURE: Hoechberg Funeral Home
ADDRESS: 4217 9th St NW
25a. REC'D BY REGISTRAR DATE: AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VR A15 (4)
15M 9/60

FOR S
HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: [illegible] permit. File pages 1 and 2 with the State Board of Health

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9238 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09228

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: BOX 59
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle L. — Last BAKER

4. DATE OF DEATH: Month AUG. — Day 9 — Year 19 61

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/21/34
9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Technical Arch.
10b. KIND OF BUSINESS OR INDUSTRY: Labor Dept.
11. BIRTHPLACE (State or foreign country): Rockville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Raymond L. Baker Sr.
14. MOTHER'S MAIDEN NAME: Grace Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): Reserves
16. SOCIAL SECURITY NO.: 218-30-2788
17. INFORMANT: Brother Rudolph Baker (Same as above) — Address: Newman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Herniation of Brain Stem — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Intracerebral Edema — 1 Day
DUE TO (c) Intra cerebral Hemorrhage — 2 days

825X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of auto involved in accident
20c. TIME OF INJURY — Hour 10 a.m. p.m. — Month, Day, Year 8-6 1961
20d. INJURY OCCURRED — While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Md R-28
20f. (City or town): Rockville — (County): Montg — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brochart M.D.
EXAMINER'S NAME (Type): Frank Brochart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-9-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/11/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National.,
22d. LOCATION (City, town, or country): Arlington, Va. — (State):

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 14 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

STATE DEPT. M 1

Page 3 should be used as a burial-transit permit. Pages 1 and 2 with a burial-transit permit should be given to the funeral director or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9239 **CERTIFICATE OF DEATH** 09229

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: MARYLAND
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Scranton 75X-3
d. STREET ADDRESS: 1425 Crown Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	HAROLD	JACOB	BARKE		August	11,	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months, Days	IF UNDER 24 HRS.: Hours, Min.
Male	White		June 26, 1924	37 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver & Warehouseman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Barke
14. MOTHER'S MAIDEN NAME: Emma Mais

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 188-12-9427
17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Insufficiency

758.5

DUE TO (b) Dilatation of Ascending Aorta

DUE TO (c) Marfan's Syndrome

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. **I certify** that (I) (this hospital) attended the deceased from August 2, 19 61 to August 11, 19 61 that (I) (we) last saw the deceased alive on August 11, 19 61 and that death occured at 2:05 PM from the causes and on the date stated above.

22a. SIGNATURE: Harry R. Keiser MD. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-11-61
22c. PHYSICIAN'S NAME (Type): Harry R. Keiser M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): SHIP. R.R.
23b. DATE THEREOF: 8-12-61
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town or county): SCRANTON (State): PA

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co Inc
ADDRESS: 1400 Chapin St N.W. Wash D.C.
25a. REC'D BY REGISTRAR DATE: AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9240

CERTIFICATE OF DEATH

09230

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 21
d. STREET ADDRESS: 10420 Eastwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nathaniel — Middle: Merritt — Last: Batchelor
4. DATE OF DEATH: Month: Aug — Day: 21 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 4, 1907
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: John Batchelor
14. MOTHER'S MAIDEN NAME: Anna Lancaster
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): W War II
16. SOCIAL SECURITY NO.: unobtainable
17. INFORMANT: Decedent — Address: --

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hyper Kalemia — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
451X
DUE TO (b) Renal failure — 24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Aortic aneurysm, dissecting, ruptured - post-op. — 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 16 1961, to August 21, 1961, that (I) (we) last saw the deceased alive on August 21 1961 and that death occured at 11:00 M, from the causes and on the date stated above.

22a. SIGNATURE: Raymond Bradshaw, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 21, 1961
22c. PHYSICIAN'S NAME (Type): Raymond Bradshaw
22d. ADDRESS: 345 Univ. Blvd, W Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cem.
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: The J.D. Hines Co.
ADDRESS: 2901 14th ST. NW. Washington DC.
REC'D BY REGISTRAR DATE: AUG 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Dir

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9241 **CERTIFICATE OF DEATH** 09231

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rockville
d. STREET ADDRESS: 1801 Douglas Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Linwood; Middle: A.; Last: Bell
4. DATE OF DEATH: Month: Aug; Day: 2; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/25/09
9. AGE (In years lost birthday): 52 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: individuals
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Luther Bell
14. MOTHER'S MAIDEN NAME: Clifter Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-0516
17. INFORMANT: Sadie Bell — Address: Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — 1 d
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1957 to 8/2/1961, that (I) (we) last saw the deceased alive on 8/2/1961, and that death occurred at 7:25 AM, from the causes and on the date stated above.

22a. SIGNATURE: Stephen N. Jones M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/2/61
22c. PHYSICIAN'S NAME (Type): Stephen N. Jones
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/6/61
23c. NAME OF CEMETERY OR CREMATORY: St. Paul
23d. LOCATION (City, town, or county) (State): Olney, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR: DATE AUG 7 '61
25b. REGISTRAR'S SIGNATURE: Clifford L. Stearns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9242 **CERTIFICATE OF DEATH** 09232

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 12117 Otis Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: Charles — Last: Berk

4. DATE OF DEATH: Month: 8 — Day: 17 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 10-4-08
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Berk
14. MOTHER'S MAIDEN NAME: Lena Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-03-0124
17. INFORMANT: Mrs Esther Berk — Address: 12117 Otis Dr Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO (b): Pulmonary adenomatosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1997

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1958 to 8/16, 1961, that (I) (we) last saw the deceased alive on 8/16, 1961, and that death occured at 12:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Charles M. Weber M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/17/61
22c. PHYSICIAN'S NAME (Type): CHARLES M. WEBER, MD
22d. ADDRESS: 12600 PARKLAND DR. ROCKVILLE MD

23a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): BURIAL
23b. DATE THEREOF: AUG. 18, 1961
23c. NAME OF CEMETERY OR ~~CREMATORY~~: KING DAVID MEMORIAL GARDEN
23d. LOCATION (City, town or county) (State): FALLS CHURCH Va.

24 FUNERAL DIRECTOR'S SIGNATURE: B. Danzansky & Sons — ADDRESS: 3501-14 St. N.W.
25a. REC'D BY REGISTRAR DATE: AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9243

CERTIFICATE OF DEATH

09233

1. PLACE OF DEATH
a. COUNTY: Montgomery County, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4
d. STREET ADDRESS: 812 Dunbarton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Bernadette; Last: (MELLETT) BERRY

4. DATE OF DEATH: Month: August; Day: 20; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 9, 1921

9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Joseph Mellett

14. MOTHER'S MAIDEN NAME: Mary Flynn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: (Husband) Frank Hauthe Berry Address 812 Dunbarton Ave., Baltimore, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO (b) Rheumatic Heart Disease mitral and aortic valve involvement — 27 years

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 10X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocardial infarction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 17, 1961, to August 20, 1961, that (I) (~~we~~) last saw the deceased alive on August 20 1961, and that death occured at 1:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: L. N. Cahill
L. N. CAHILL, LCDR MC USN M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 20, 1961

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: U.S. Naval Hospital, NNMC, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (State): Removal and Burial

23b. DATE THEREOF: 8-24-61

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

23d. LOCATION (City, town or county) (State): Baltimore Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. Stevens ADDRESS: Funeral Home, Inc. 1501 E. Fort Ave.

25a. REC'D BY REGISTRAR DATE AUG 23 '61

25b. REGISTRAR'S SIGNATURE: Anthony E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9244 09234

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck
c. LENGTH OF STAY IN 1b: 23 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 15015 Rosecroft Road.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck
d. STREET ADDRESS: 15015 Rosecroft Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Stewart Last: Black

4. DATE OF DEATH: Month: Aug Day: 12 Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 7, 1903

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clarence Thomas Stewart

14. MOTHER'S MAIDEN NAME: Halloran, Agnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 578-32-2316

17. INFORMANT — Address: Agnes H. Stewart, 15015 Rosecroft Rd, Norbeck

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the uterus. — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(b)
DUE TO
(c)

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1959 to Aug 12, 1961, that (I) (we) last saw the deceased alive on Aug 12 1961, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Lillian K. Ziegler M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 12, 1961

22c. PHYSICIAN'S NAME (Type): Lillian K. Ziegler

22d. ADDRESS: 202 Princess Anne Drive, Olney, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/16/61

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeska — ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue

25a. REC'D BY REGISTRAR DATE: AUG 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9245 — 09235

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1119 S. Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emily — Middle: Yellott — Last: Blandford

4. DATE OF DEATH: Month: Aug — Day: 6 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7-1-1883

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months ___ Days ___

IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Yellott

14. MOTHER'S MAIDEN NAME: Nannie Gittings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give year or dates of service):

16. SOCIAL SECURITY NO.: Yes Unknown

17. INFORMANT: John Elgin (Son-in-law) — Address: P.O. Box 483 Rockville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
540.0
DUE TO (b) Eroded Gastric Artery (Arteriosclerotic) — Sudden
DUE TO (c) Acute Gastric Ulcer — Recent

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart M.D.

EXAMINER'S NAME (Type) FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED 8-7-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/9/61

22c. NAME OF CEMETERY OR CREMATORY: Trinity Church Cem.

22d. LOCATION (City, town, or country) (State): Towson, Maryland

23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE AUG 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

9246

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09235

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 4½ mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Wheaton~~ Silver Spring
d. STREET ADDRESS: 18812 Second Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nannie — Middle: Josephine — Last: Boland
4. DATE OF DEATH: Month: Aug — Day: 4 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-17-1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Dep. Store
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Peter J. Boland
14. MOTHER'S MAIDEN NAME: Lydia Jenkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 577-01-5444
17. INFORMANT: Nursing Home Record — Address:

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of sigmoid — INTERVAL BETWEEN ONSET AND DEATH: mos. Hrs.
153.3
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-4-61
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): XXXXXXXX
22b. DATE THEREOF: 8-7-61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Pumphrey — WARNER E. PUMPHREY, INC. — ADDRESS: 8434 Georgia Ave., Silver Spring, Md.
24a. REC'D BY REGISTRAR, DATE: AUG 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Shaw

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9247 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09237

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 708 Phila. Ave. Cwr-Ln Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 18 Takoma Pk
d. STREET ADDRESS: 7216 Spruce Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline; Middle: Cooper; Last: Bowen

4. DATE OF DEATH: Month: Aug; Day: 2; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-20-1876

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Wm. R. MacFarlane

14. MOTHER'S MAIDEN NAME: Caroline Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Nursing Home Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO
(b): Arteriosclerotic heart disease — Months
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 8-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Aug-3-61

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or country) (State): Hyattsville Md. Prince Geo. Co.

23. FUNERAL DIRECTOR: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W.

24a. REC'D BY REGISTRAR DATE: AUG 3 '61

24b. REGISTRAR'S SIGNATURE: Arthur E. Hume

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M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9248 **CERTIFICATE OF DEATH** 09238

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: June-Aug.1961
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 11,111 Lund Place

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: New York
b. COUNTY: ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): NEW YORK CITY
d. STREET ADDRESS: 200 W. 58th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Annie; Middle — Marie; Last — Bowman
4. DATE OF DEATH: Month — Aug.; Day — 17; Year — 1961
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 12, 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife retired
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John Bifield
14. MOTHER'S MAIDEN NAME: Annie Doyle Bifield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: J.Lee Sugrue, 11,111 Lund Place, Kensington, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) cerebral thrombosis — 1 wk.
DUE TO (c) arteriosclerosis — 10-15 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive Heart Failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 1957 to Aug 17 1961, that (I) (we) last saw the deceased alive on Aug 16 1961, and that death occured at 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Sanford J Randall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/17/61
22c. PHYSICIAN'S NAME (Type): Dr.Sanford Randall
22d. ADDRESS: 8329 Grubb Rd.Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: AUG.19,1961
23c. NAME OF CEMETERY OR CREMATORY: Mt.Olivet Cemetery
23d. LOCATION (City, town or county) (State): Wash.D.C.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: WARNER E. PUMPHREY INC. SILVER SPRING, MD. Raymond A. Zska
25a. REC'D BY REGISTRAR DATE: AUG 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9249 **CERTIFICATE OF DEATH** 09239

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital, Bethesda

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 102 Dawson Ave
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Boyd
4. DATE OF DEATH: Month: August — Day: 23 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 21, 1961
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months — Days 3 IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Earl Luther Boyd
14. MOTHER'S MAIDEN NAME: Dorothy Marie Howard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father — Address: (same as Above)

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS & MENINGOMYELOCELE — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

7 52X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-21, 1961, to 8-22, 1961, that (I) (we) last saw the deceased alive on 8-22 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Warthen M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-23-1961
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 26, 61
23c. NAME OF CEMETERY OR CREMATORY: Laytonsville
23d. LOCATION (City, town or county): Laytonsville (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis W. Barber ADDRESS: Laytonsville Md.
25a. REC'D BY REGISTRAR DATE SEP 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2074354 XV6

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9250 — 09240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

074

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 3545 Albemarle St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: C. — Last: Bradley

4. DATE OF DEATH: Month: August — Day: 31 — Year: 19 61

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 3/ 10/ 84
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Wash. D.C
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Joseph Bradley
14. MOTHER'S MAIDEN NAME: Mary Hooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Army
16. SOCIAL SECURITY NO.:
17. INFORMANT: Daughter Mrs. Lois Baker — Address: 4518 Dresden St. Kensington, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Leukemia, Myelogenous, acute — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
204.3
DUE TO (b): Cause unKnown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute gastro-enteritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956 to Aug 31, 1961, that (I) (~~we~~) last saw the deceased alive on Aug 30 1961, and that death occured at 7 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Edward Clapp M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9.31.61
22c. PHYSICIAN'S NAME (Type): Stewart Clapp M.D.
22d. ADDRESS: 4740 Chevy Chase Dr. Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/5/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
23d. LOCATION (City, town or county) (State): Arlington Va

24 FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home — ADDRESS: 5824 Wis. Ave. Wash. D.C.
25a. REC'D BY REGISTRAR — DATE: SEP 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9251

CERTIFICATE OF DEATH

Reg. Dist. No. 09241

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laytonsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laytonsville
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Martha; Middle: J.; Last: Bradshaw

4. DATE OF DEATH: Month: August; Day: 11; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 8, 1897
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: 10; Days: 3
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - -
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~Unknown~~ Charles Samuel Tudor
14. MOTHER'S MAIDEN NAME: Minnie Harriger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Samuel Tudor-Same Item #2 Son — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) C.V.A.
DUE TO
(c) Hypertension

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1958, 19__, to 8-11-61, 19__, that I last saw the deceased alive on 8-11-61, 19__, and that death occurred at 7:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Luciano J. Leal M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:
PHYSICIAN'S NAME (Type): Luciano J. Leal. Gaithersburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-trans
22b. DATE THEREOF: 8/11/1961
22c. NAME OF CEMETERY OR CREMATORY: Taylor Cemetery
22d. LOCATION (City, town, or county) (State): Falls Creek Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE AUG 14 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9252

CERTIFICATE OF DEATH

09242

M

C 073

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 29 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE 06X-2
d. STREET ADDRESS: GAITHER ROAD
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY Middle BOY "A" Last BROWN
4. DATE OF DEATH: Month AUGUST Day 18 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 18, 1961
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEW BORN
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): MONTGOMERY CO., MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME: HERBERT EUGENE BROWN
14. MOTHER'S MAIDEN NAME: MILLIE MARIE HAMILTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FATHER Address: ABOVE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 29 minutes
769.9
DUE TO (b) Prematurity, one of the twins.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Polyhydramnios of pregnancy.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 8-18, 1961, to 8-18, 1961, that (I) ~~(we)~~ last saw the deceased alive on 8-18 1961, and that death occured at 8:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Sam Okutman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-18-61
22c. PHYSICIAN'S NAME (Type): A. S. OKUTMAN, M. D.
22d. ADDRESS: SYKESVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-18-61
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Rakestraw Memorial Park
23d. LOCATION (City, town or county) (State): Sykesville, Carroll Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Ruth H. Haight ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9253

CERTIFICATE OF DEATH

09243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M C I

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 30 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where decedent lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
d. STREET ADDRESS: GAITHER ROAD 06 X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY — Middle: BOY "B" — Last: BROWN

4. DATE OF DEATH: Month: AUGUST — Day: 18 — Year: 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: AUGUST 18, 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEW BORN
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): MONTGOMERY Co., MARYLAND
12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: HERBERT EUGENE BROWN
14. MOTHER'S MAIDEN NAME: MILLIE MARIE HAMILTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: FATHER — Address: ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
769.9
DUE TO (b) Prematurity, one of the twins
DUE TO (c) polyhydramnios of pregnancy.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 8-18, 1961, to 8-18, 1961, that (I) (~~we~~) last saw the deceased alive on 8-18 1961, and that death occured at 9:25 AM, from the causes and on the date stated above.

22a. SIGNATURE: Sam Okutman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/18/61
22c. PHYSICIAN'S NAME (Type): A. S. OKUTMAN, M. D.
22d. ADDRESS: SYKESVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-18-61
23c. NAME OF CEMETERY OR CREMATORY: Lakeview Memorial Park
23d. LOCATION (City, town or county) (State): Sykesville Carroll Co., Md

24 FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.
25a. RECEIVED BY REGISTRAR AUG 29 61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

2273182XVO

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9254

CERTIFICATE OF DEATH

09244

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 Mo.-7 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Philadelphia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia 75X-3
d. STREET ADDRESS: 202 E. Tioga Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pamela; Middle: Lynn; Last: BUCK
4. DATE OF DEATH: Month: August; Day: 19; Year: 1961
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 18, 1961
9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months 4, Days 1; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dependent Child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Edward BUCK
14. MOTHER'S MAIDEN NAME: Dorothy Jennie ARNOLD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (Father) Frank Edward BUCK — Address: 202 E. Tioga St., Philadelphia, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive failure
DUE TO (b) Congenital Heart Disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
754.5

INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 July, 1961 to 19 August, 1961, that (I) (~~we~~) last saw the deceased alive on 19 August 1961, and that death occured at 7:55 PM from the causes and on the date stated above.

22a. SIGNATURE: L. N. Cahill M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 20 August 1961
22c. PHYSICIAN'S NAME (Type): L. N. CAHILL, LCDR MC USN
22d. ADDRESS: U. S. Naval Hospital, NNMC, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 21Aug 1961
23c. NAME OF CEMETERY OR CREMATORY: Hillside Cemetery
23d. LOCATION (City, town or county) (State): Roslyn, Pennsylvania
24. FUNERAL DIRECTOR'S SIGNATURE: Robert J. Pumphrey FOR Wildey Funeral Home
ADDRESS: Bethesda, Md. Philadelphia, Pa.
25a. REC'D BY REGISTRAR DATE AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9255 **CERTIFICATE OF DEATH** 09245

M C 099

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 46 Bethesda
d. STREET ADDRESS: 1 8808 Lowell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul; Middle: Jeffrey; Last: Buck

4. DATE OF DEATH: Month: August; Day: 23; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1961
9. AGE (In years last birthday) yrs.; IF UNDER 1 YEAR: Months 3, Days 7; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Max Buck
14. MOTHER'S MAIDEN NAME: Margaret Valda Osburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert Max Buck — Address: 8808 Lowell St. Bethesda, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Congenital heart disease (Tetralogy of Fallot) — 3 months
DUE TO (c):

754.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from May 16, 1961, to Aug 23, 1961, that (I) (~~we~~) last saw the deceased alive on Aug 1 1961, and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Harold M. Hobart, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-23-61
22c. PHYSICIAN'S NAME (Type): Harold M. Hobart
22d. ADDRESS: 5402 CONN. AVE. NW. Wash. 15. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 8/25/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co.
ADDRESS: 2901 14th St. NW Washington, D.C.
25a. REC'D BY REGISTRAR: DATE AUG 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/60

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FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9256

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09246

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wood Acres
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6221 ~~5221~~ Massachusetts Avenue, Extended

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wood Acres
d. STREET ADDRESS: 6221 ~~5221~~ Massachusetts Avenue, Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth Earl; Middle: Buffin; Last:
4. DATE OF DEATH: Month: August; Day: 10; Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 10, 1888
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Colonel, U.S.A.
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Williamsburg Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Buffin
14. MOTHER'S MAIDEN NAME: Margaret Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give wars or dates of service): WW1. & WW2.
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Florence A. Buffin — Address: 5221 Massachusetts Avenue, Wood Acres, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: August 8, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): ~~XXXXX~~ Burial
22b. DATE THEREOF: 8/14/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nationnl Cemetery
22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: Raymond A. Ziska — Warner E. Pumphrey, Inc. — ADDRESS: Silver Spring, Maryland 8434 Georgia Avenue
24a. REC'D BY REGISTRAR: AUG 14 '61 — DATE
24b. REGISTRAR'S SIGNATURE: Arthur L. Flynn

Item 20 Film 293 8-25

Item 20
Film 297
10-61ams

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09247

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 24 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery County Jail

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 18 W. Montgomery Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sherman — Middle: Lee — Last: Burke
4. DATE OF DEATH: Month: Aug — Day: 17 — Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-12-1926
9. AGE (In years last birthday): 34 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Contractors.
11. BIRTHPLACE (State or foreign country): Virginia.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Andrew Jackson Burke
14. MOTHER'S MAIDEN NAME: Ida Light
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes. (If yes give war or dates of service): World War II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Annie W. Burke — 103 - High St. Christiansburg Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral Edema — INTERVAL BETWEEN ONSET AND DEATH: Hours
904.7
DUE TO (b) Subdural Hematoma, Left — unknown
DUE TO (c) Fractured Skull, Left Parietal Bone, Comminuted — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): UNDETERMINED Fell
20c. TIME OF INJURY: Hour 3:30 a.m. p.m. Month, Day, Year: Unknown 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Mont Co. Unknown/Jail
20f. (City or town): Rockville /Unknown/ (County): Mont (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Frank J. Boschant M.D.
EXAMINER'S NAME (Type): FRANK J. BHOSCHANT
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 8/19/61
22c. NAME OF CEMETERY OR CREMATORY: Sunset
22d. LOCATION (City, town, or country) (State): Christiansburg, Virginia

23. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 21 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9258 — 09248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 2802 Jennings Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: J. — Last: CARPENTER
4. DATE OF DEATH: Month: August — Day: 7 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 26 1914
9. AGE (In years lost birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jesse N. Hawley
14. MOTHER'S MAIDEN NAME: Eva Bulkey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-38-2791
17. INFORMANT: (John C. Carpenter) husband — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial Glomerulo Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO (b) Diabetes Mellitus — 15 yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ——— 1947, to August 7, 1961, that (I) (~~was~~) last saw the deceased alive on August 7, 1961, and that death occurred at 10:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Dewitt E. DeLawter M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-7-61
22c. PHYSICIAN'S NAME (Type): DeWitt E. DeLawter, M.D.
22d. ADDRESS: 8025 Aberdeen Rd. Beth. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/10/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town, or county) (State): Rockville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: AUG 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9259 **CERTIFICATE OF DEATH** 09249

Item 1 Film G294 9/7/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bethesda Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Dist. of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 4931-N. Capitol. Apt. 24
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Enrico Middle: Joseph Last: Carpenti
4. DATE OF DEATH: Month: Aug. Day: 25 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/6/16
9. AGE (In years last birthday): 45 Yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cleaner
10b. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (County & State, or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Vincent Carpenti
14. MOTHER'S MAIDEN NAME: Maria Riccone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 219-18-1182
17. INFORMANT: Adeline Carpenti Address: Same As Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Influenza Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Coma — 6 days
DUE TO (c): Cerebral Hemorrhage

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 20, 1961 to Aug 25, 1961, that (I) (we) last saw the deceased alive on 4 PM 1961, and that death occured at 4 PM, from the causes and on the date stated above.

22a. SIGNATURE: J. P. Murphy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): J.P. MURPHY, M.D.
22d. ADDRESS: 1904 R St NW WASH. 9 DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/28/61
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION (City, town or county) (State): Silver Spring, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Arthur C. Vincent
ADDRESS: 2525 Bladensburg Rd. N.E. D.C. Wash
25a. REC'D BY REGISTRAR DATE AUG 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

9260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09250

Items 3 & 7 Film 6292 8/15/61 1wk

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENSINGTON GARDENS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 2221 FOREST GLEN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: ELIZABETH — Last: CHEENEY

4. DATE OF DEATH: Month: AUG. — Day: 4 — Year: 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 28, 1888
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): File Clerk (Ret)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.
11. BIRTHPLACE (State or foreign country): Massachusets
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: WILLIS CHEENEY
14. MOTHER'S MAIDEN NAME: LOUISE MORTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MR. WM. CHEENEY — Address: 2221 FOREST GLEN RD. SILVER SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL INFARCTIONS — INTERVAL BETWEEN ONSET AND DEATH: 4-5 YRS.
DUE TO
(b) CEREBRAL ATHEROSCLEROSIS — 5-7 YRS.
DUE TO
(c) DIABETES MELLITUS, — –

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS ~~CONTRIBUTING TO DEATH~~ BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CA COLON OPERATED 1955 - NON CONTRIBUTORY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) –
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from FEB. 22 1958, to AUG. 4 1961, that (I) (we) last saw the deceased alive on AUG 4 1961, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James A. Roberts M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: AUG. 4, 1961
22c. PHYSICIAN'S NAME (Type): JAMES A. ROBERTS
22d. ADDRESS: 8907 GEO. AVE. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/7/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisko
ADDRESS: Silver Spring, Md.
Warner E. Pumphrey, Inc. 8434 Georgia Avenue
25a. REC'D BY REGISTRAR DATE AUG 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9261 — 09251

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4Hrs & 13 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 6010 37th Ave.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

1660-2

3. NAME OF DECEASED (Type or print): First: Timothy — Middle: — Last: CHRETIEN

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: August 1, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 4 — Min.: 13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Paul A. Chretien

14. MOTHER'S MAIDEN NAME: Kathleen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Paul A. Chretien — Address: Same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Erythroblastosis fetalis — INTERVAL BETWEEN ONSET AND DEATH: Congenital
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

770.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 1, 1961 to August 1, 1961 that (I) (we) last saw the deceased alive on August 1, 1961, and that death occured at 7:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Lawrence G. Thorne M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: August 1, 1961
22c. PHYSICIAN'S NAME (Type): Lawrence G. Thorne, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 4, 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Fort Myer Va.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers
ADDRESS: 5801 Cleveland Ave. Riverdale, Md.

25a. REC'D BY REGISTRAR DATE: AUG 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

20513+7XV5

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9262

CERTIFICATE OF DEATH

Reg. Dist. No. 09252

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ednor

c. LENGTH OF STAY IN 1b: Five weeks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9318 ~~xxxxxxx~~ Wheaton, Silver Spring

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BELMONT NURSING HOME

d. STREET ADDRESS: ~~xxxxxxxxxxxxxx~~ Forest Glen, Md

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle Last CLARK

4. DATE OF DEATH: Month 8 Day 2 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/1/1876

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHOTOGRAPHER

10b. KIND OF BUSINESS OR INDUSTRY: US GOVT.

11. BIRTHPLACE (State or foreign country): MICHIGAN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT H. CLARK

14. MOTHER'S MAIDEN NAME: EVA JACKSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: NURSING + MEDICAL RECORD Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY EMBOLUS — 1 HR

DUE TO

(b) CONGESTIVE HEART FAILURE — 1 WK

DUE TO

(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): RECENTLY POSTOPERATIVE (TRANS URETHRAL PROSTATECTOMY)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/9, 19 61, to 8/2, 19 61, that I last saw the deceased alive on 7/31, 19 61, and that death accurred at 11:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John P. Martin M.D. ADDRESS (Street, city or town, state): Sandy Spring DATE SIGNED: 8/2/61

PHYSICIAN'S NAME (Type): JOHN P MARTIN, MD SANDY SPRING, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 8/4/61

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

22d. LOCATION (City, town, or county) (State): Prince George's County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zska ADDRESS: Silver Spring, Maryland Warner E. Pumphrey, Inc. 8434 Georgia Avenue

24a. REC'D BY REGISTRAR DATE AUG 7 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9263 **CERTIFICATE OF DEATH** 09253

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 717 Ritchie Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 717 Ritchie Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah Middle: Emma Last: Clark
4. DATE OF DEATH: Month: 8 Day: 16 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 21, 1884
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Montgomery County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Mr. James Harvey
14. MOTHER'S MAIDEN NAME: Georgianna Goddard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Address: Mrs. May A. Young 8623 Flower Avenue Takoma Park Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: 2 months
600.0
DUE TO (b): Chronic pyelonephritis — Many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinomatosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from August, 1959, to August 16, 1961, that (I) ~~(we)~~ last saw the deceased alive on August 14 1961, and that death occured at 9 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: August 16, 1961
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr. M.D.
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/19/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George's County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Warner W. Pumphrey, Inc. ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9264

CERTIFICATE OF DEATH

09254

Items 2, 11, 14 & 16 Film 6297 10/2/61 mh

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. STATE: MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 73 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Michigan~~ California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Detroit~~ San Francisco
d. STREET ADDRESS: ~~3710 Burlingame Avenue~~ 760 8th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

S4X-3

3. NAME OF DECEASED (Type or print): First: Solly; Middle: (None); Last: Cohen
4. DATE OF DEATH: Month: August; Day: 12; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 15, 1915
9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Spotter
10b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning
11. BIRTHPLACE (County & State, or foreign country): ~~New York~~ Toronto, Can.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Issac Cohen
14. MOTHER'S MAIDEN NAME: Bessie ~~Schallnes~~ Schaaltes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 562-12-9578
17. INFORMANT: ~~Unascertainable~~ The Medical Record The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO (b) Widespead Epidermoid Carcinoma (Primary - left Alveolar ridge) — 6 months

DUE TO (c)

144X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 3 days post-operative Medullary Tractotomy for Intractable Pain

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from May 31, 1961 to August 12, 1961, that ☒ (we) last saw the deceased alive on August 12, 1961, and that death occured at 9:15 AM from the causes and on the date stated above.

22a. SIGNATURE: J. Kent Trinkle M.D.
22b. DATE SIGNED: 8/12/61
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): J. Kent Trinkle, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): BURIAL
23b. DATE THEREOF: AUG 15 1961
23c. NAME OF CEMETERY ~~OR CREMATORY~~: CHESED-SHEL EMMES
23d. LOCATION (City, town or county) (State): HILLSIDE Md

24 FUNERAL DIRECTOR'S SIGNATURE: Dangowsky & Sons
ADDRESS: 3501-14th St. NW.
25a. REC'D BY REGISTRAR DATE: AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9265 **CERTIFICATE OF DEATH** 09255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 6710 Hillandale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Persis Middle: C. Last: Coiner
4. DATE OF DEATH: Month: Aug. Day: 19 Year: 1961
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4/26/1905
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Fairfax Conrad
14. MOTHER'S MAIDEN NAME: Martha Proudfit
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Gordon C. Coiner — Address: Silver Spring, MD 1732 East West Hgway.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Peritonitis	3 wks
DUE TO (b)	Perforated Appendicitis	3 wks
DUE TO (c)		

550.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ulcerative Colitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/22, 1961, to 8/19/, 1961, that (I) (we) last saw the deceased alive on 8/19/ 1961, and that death occured at 2:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Leon Gerber M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): LEON GERBER M.D.
22d. ADDRESS: 1800 Eye St. N. W. Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE THEREOF: 8/19/61
23c. NAME OF CEMETERY OR CREMATORY: Ware Episcopal Cem.
23d. LOCATION (City, town or county) (State): Gloucester, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: Washington, D. C.
25a. REC'D BY REGISTRAR DATE: AUG 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

M

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9266

CERTIFICATE OF DEATH

Reg. Dist. No. 09256

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
c. LENGTH OF STAY IN 1b: 84 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kesmer Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Washington D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 4712 Brandywine St N.W. 5711 Broadbeck Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

47 X-3

3. NAME OF DECEASED (Type or print): First: George — Middle: Thomas — Last: Collins
4. DATE OF DEATH: Month: August — Day: 16 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7, 1877
9. AGE (In years lost birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Banker
11. BIRTHPLACE (State or foreign country): Georgetown, Wash. D.C.
12. CITIZEN OF WHAT COUNTRY?

I

13. FATHER'S NAME: Andrew Collins
14. MOTHER'S MAIDEN NAME: Mary Ann Regan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-12-1079
17. INFORMANT: Mrs Jessie H Collins — Address: 4712 Brandywine St N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA, BRONCHIAL — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO (b): PULMONARY EDEMA — 4 MONTHS
DUE TO (c): ARTERIOSCLEROTIC HEART DISEASE — 10+ YEARS

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ESSENTIAL HYPERTENSION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): N/A
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/11, 1961, to 8/16, 1961, that I last saw the deceased alive on 8/15, 1961, and that death occurred at 9:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles Savarese M.D. — ADDRESS (Street, city or town, state): 4890 Battery La. — DATE SIGNED: 8/16/61

PHYSICIAN'S NAME (Type): CHARLES J. SAVARESE JR. MD — BETHESDA, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/21/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l
22d. LOCATION (City, town, or county) (State): Arlington Va

23. FUNERAL DIRECTOR'S SIGNATURE: Henry Chase Funeral Home — ADDRESS: 5103 Wisconsin Ave N.W.
24a. REC'D BY REGISTRAR: DATE AUG 21 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9267

CERTIFICATE OF DEATH

09257

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RESMOR HOSPITAL + SAN.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: — — — —
b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C.
d. STREET ADDRESS: 1821 SUMMIT PL N.W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: MARY HOWARD CORBETT

4. DATE OF DEATH: Month — Day — Year: AUGUST 27 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG 26 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — — —
10b. KIND OF BUSINESS OR INDUSTRY: — — — —
11. BIRTHPLACE (County & State, or foreign country): ARLINGTON, VA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CHARLES CORBETT
14. MOTHER'S MAIDEN NAME: MARY HOWARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give year or dates of service): — —
16. SOCIAL SECURITY NO.: — — —
17. INFORMANT: PAUL WALTER — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
5721
DUE TO (b): UREMIA — 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): DIVERTICULITIS — 8 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/23, 1961, to 8/27, 1961, that (I) (we) last saw the deceased alive on 8/27 1961, and that death occured at 8:45 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Brewer M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/27/61
22c. PHYSICIAN'S NAME (Type): ROBERT G. BREWER
22d. ADDRESS: 8218 WISCONSIN AVE BETH MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 8-30-1961
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Suitland. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gaulesi Sons
ADDRESS: 1756 Pa Ave N.W. Wash, D.C.
25a. REGISTRAR DATE: AUG 29 61
25b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be explained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9268 **CERTIFICATE OF DEATH** 09258

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 29 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 234 Eye Street, S.W.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: Eugene — Last: Costanzo

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 7, 1927

9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Kittredge

14. MOTHER'S MAIDEN NAME: Mildred Mercer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 579-30-5105

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) right heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hours
DUE TO (b) Bilateral atelectasis, Respiratory failure & — 8 years
DUE TO (c) Pulmonary Hypertension — 8 years
Myxoma - left atrium — 8 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

227X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 3, 1961 to August 1, 1961 that ☒ (we) last saw the deceased alive on August 1, 1961, and that death occured at 12:57 AM, from the causes and on the date stated above.

22a. SIGNATURE W. Douglas Clark M.D.

22b. DATE SIGNED: 8/1/61 — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): W. Douglas Clark, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3 AUG. 1961

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET

23d. LOCATION (City, town or county) (State): WASHINGTON DC.

24 FUNERAL DIRECTOR'S SIGNATURE: Michael J. Perardi Jr. — Funeral Home — ADDRESS: 816 H ST NE WASH. 2, DC

25a. REC'D BY REGISTRAR DATE: AUG 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9269

CERTIFICATE OF DEATH

Reg. Dist. No. 09259

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA. b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington. 47X-3
d. STREET ADDRESS: 1401 Tuckerman St NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth Middle: Payne Last: Craft.

4. DATE OF DEATH: Month: Aug. Day: 5 Year: 1961

5. SEX: Male.
6. COLOR OR RACE: Wh.
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: Sept 6, 1898
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Leroy Craft.
14. MOTHER'S MAIDEN NAME: Cora Payne.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 578-07-6853
17. INFORMANT: Mrs. Barbara Nicholas. Address: 938 Northampton Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung — INTERVAL BETWEEN ONSET AND DEATH: 5 mos.
DUE TO (b) c̄ metastases.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER): —
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY Hour a. m. p. m.: — Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) (County) (State): —

21. I certify that I attended the deceased from July 17, 1961, to Aug 5, 1961, that I last saw the deceased alive on Aug 5, 1961, and that death occurred at 10 50 A.M./P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James L. Laubach M.D. ADDRESS (Street, city or town, state): 1806 FOX St. DATE SIGNED: 8/5/61.
PHYSICIAN'S NAME (Type): James L. Laubach Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/8/61
22c. NAME OF CEMETERY OR CREMATORY: Maple Grove (Grove)
22d. LOCATION (City, town, or county) (State): Worcester, N. Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph F. Birch's Sons ADDRESS: Washington, D.
24a. REC'D BY REGISTRAR DATE: AUG 8 '61
24b. REGISTRAR'S SIGNATURE: Orlan S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9270 **CERTIFICATE OF DEATH** 09260

Item 23 Film G294 9/6/61 mh

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 65 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where decedent lived, If institution: Residence before admission)
a. STATE: Tennessee
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Memphis
d. STREET ADDRESS: 1608 S. Lauderdale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

79X-3

3. NAME OF DECEASED (Type or print): First: Laurie Middle: Renae Last: Crawford
4. DATE OF DEATH: Month: August Day: 28 Year: 1961
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-23-61
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months 4 Days 5 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ellie L. Crawford
14. MOTHER'S MAIDEN NAME: Rita J. Yates
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MENINGITIS — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS.
DUE TO (b) INFECTED VENTRICULO ATRIAL SHUNT — 8 DAYS -
DUE TO (c) HYDROCEPHALUS,

344.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): LARYNGO MALACIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from June 24, 1961 to August 28, 1961, that ~~I~~ (we) last saw the deceased alive on August 28 1961, and that death occured at 4:00 AM from the causes and on the date stated above.

22a. SIGNATURE: R. W. MacKie M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 28, 1961
22c. PHYSICIAN'S NAME (Type): R. W. MACKIE, CAPTAIN, MC,USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shippment
23b. DATE THEREOF: 30 August 1961
23c. NAME OF CEMETERY OR CREMATORY: Unknown
23d. LOCATION (City, town or county): Memphis (State): Tennessee

24. FUNERAL DIRECTOR'S SIGNATURE: Frazier's Funeral Home
ADDRESS: Washington, D.C. 389 Rhode Island Ave. N.W.
25a. REC'D BY REGISTRAR DATE: AUG 30 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Knowles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M C 051 I 0 1

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9271

CERTIFICATE OF DEATH

09261

1

M

C

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 HRS. 20 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Olney
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LILLIAN — Middle: SUE — Last: Crown

4. DATE OF DEATH: Month: August — Day: 26 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ NB

8. DATE OF BIRTH: August 26, 1961

9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours 3 — Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - -

10b. KIND OF BUSINESS OR INDUSTRY: - -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Crown

14. MOTHER'S MAIDEN NAME: Lillian Virginia ~~Crown~~ Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): -
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure
DUE TO (b): Arrenceplalic.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-26, 1961 to 8-26, 1961 that (I) (we) last saw the deceased alive on 8/26 1961, and that death occured at 5:25 p.M, from the causes and on the date stated above.

22a. SIGNATURE: Luciano R. Leal M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/28/61

22c. PHYSICIAN'S NAME (Type): L. I. Leal, M. D.

22d. ADDRESS: Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-28-61

23c. NAME OF CEMETERY OR CREMATORY: Forest Oak

23d. LOCATION (City, town or county) (State): Gaithersburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Layfonsville - Md.

25a. REC'D BY REGISTRAR — DATE: SEP 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9272

CERTIFICATE OF DEATH

Reg. Dist. No. 09262

M

090

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marilea Nursing Home, 14,511 Colesville Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland D.C.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Wash. 47X-3
d. STREET ADDRESS: 7444 Georgia Avenue, N.W. Apt. 201
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Herbert; Last: David
4. DATE OF DEATH: Month: August; Day: 9; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 7, 1876
9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Automobile Distributor
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): Clarion County, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emil David
14. MOTHER'S MAIDEN NAME: Sarah Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.:
INFORMANT: Mr. Harold H. David — Address: 7452 Alaska Avenue, N.W. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart failure with — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO (b) widespread metastases
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

180X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 28, 1961, to Aug. 7, 1961, that I last saw the deceased alive on Aug 7, 1961, and that death occurred at 1:20 p.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John S. Rogers, M.D. — ADDRESS (Street, city or town, state): 19,9 Seminary Rd — DATE SIGNED: Aug. 7, 61
PHYSICIAN'S NAME (Type): Silver Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/11/61
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Zska — ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue
24a. REC'D BY REGISTRAR: DATE AUG 14 '61
24b. REGISTRAR'S SIGNATURE: Irvin S. Stone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9273

CERTIFICATE OF DEATH

09263

M

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 53 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 Bethesda
d. STREET ADDRESS: 4507 Chase Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

074

3. NAME OF DECEASED (Type or print): First: Lena Middle: Elizabeth Last: Fay
4. DATE OF DEATH: Month: Aug. Day: 20 Year: 1961
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 8, 1886
9. AGE (In years lost birthday): 75 yrs. IF UNDER 1 YEAR: Months: 7 Days: 12 IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

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13. FATHER'S NAME: Frances Todd
14. MOTHER'S MAIDEN NAME: Florence Floyd
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Dorothy Fay (Sister) Address: 5 Ashe St Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): cerebral thrombosis — 6 weeks

DUE TO (c): generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): carcinoma of colon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1961 to Aug 20 1961 that (I) (we) last saw the deceased alive on August 20 1961 and that death occurred at — M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred R. Ehrman Trout M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/20/61
22c. PHYSICIAN'S NAME (Type): Alfred R. Ehrman Trout
22d. ADDRESS: 4890 Battery Lane, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town, or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex[illegible] within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9274 **CERTIFICATE OF DEATH** 09264

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Winchester 83X-3
d. STREET ADDRESS: 3130 Vally Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leman; Middle: Elroi; Last: Dehart
4. DATE OF DEATH: Month: August; Day: 12; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-10-88
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James C. Dehart
14. MOTHER'S MAIDEN NAME: Rebecca Jane Heckman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bertha S. Dehart Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma pancreas - metastatic
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma pancreas
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 5, 1961 to August 12, 1961, that (I) (we) last saw the deceased alive on August 12 1961, and that death occured at 9:10 PM, from the causes and on the date stated above.

22a. SIGNATURE: Bruce Harold Rice M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 14, 1961
22c. PHYSICIAN'S NAME (Type): BRUCE HAROLD RICE, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 16, 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington (State): Va.
24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur B. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9275

CERTIFICATE OF DEATH

09265

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 Mo. - 6 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X·3
d. STREET ADDRESS: 1754 Massachusetts Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jacobus — Middle: — Last: DIJKMAN

4. DATE OF DEATH: Month: August — Day: 18 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: February 22, 1900

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouseman

10b. KIND OF BUSINESS OR INDUSTRY: Storage

11. BIRTHPLACE (County & State, or foreign country): HOLLAND

12. CITIZEN OF WHAT COUNTRY?: HOLLAND ✓

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give were or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: (Son) Robert O. DIJKMAN — Address: 1754 Mass. Ave., Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Transitional Cell Carcinoma of the bladder, with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1948X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 12 June, 1961 to 18 August, 1961 that I (xx) last saw the deceased alive on 18 August 1961, and that death occured at 4:05 PM, from the causes and on the date stated above.

22a. SIGNATURE: L. N. Cahill M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 20 August 1961

22c. PHYSICIAN'S NAME (Type): L. N. CAHILL, LCDR MC USN

22d. ADDRESS: U. S. Naval Hospital, NNMC, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — Shipment

23b. DATE THEREOF: 22 Aug 1961

23c. NAME OF CEMETERY OR CREMATORY: Sherwood Cemetery

23d. LOCATION (City, town or county) (State): Talbot County, Maryland

24. BURIAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Robert A. Pumphrey, 7557 Wisconsin Ave. Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: AUG 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9276 **CERTIFICATE OF DEATH** 09266

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where decedent lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
d. STREET ADDRESS: RFD #1
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Brooke — Last: Dinwiddie
4. DATE OF DEATH: Month: August — Day: 26 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 30, 1886
9. AGE (In years last birthday): 75 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse, retired
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Alban Brooke
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Pleasants
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-34-7450
17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO (b) Coronary arteriosclerosis (marked)
DUE TO (c) Cardiomegaly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from December, 1960 to 8/26, 1961, that (I) ~~(we)~~ last saw the deceased alive on 8/26, 1961, and that death occured at 12:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J. P. Martin, M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] ~~STATE RHO~~ [ ]
22b. DATE SIGNED: 8/26/61
22c. PHYSICIAN'S NAME (Type): J. P. Martin, M. D.
22d. ADDRESS: Medical Center, Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 29, 1961
23c. NAME OF CEMETERY OR CREMATORY: Friends' Cemetery
23d. LOCATION (City, town or county) (State): Sandy Spring, Montg., Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisha
ADDRESS: WARNER E. PUMPHREY, INC., SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE AUG 30 '61
25b. REGISTRAR'S SIGNATURE: Colin S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be prepared by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9277

CERTIFICATE OF DEATH

09267

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 53 Chevy Chase
d. STREET ADDRESS: 31 Oxford St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: V.; Last: Dolan
4. DATE OF DEATH: Month: Aug.; Day: 16; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/29/03
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Gaylordville, Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Dolan
14. MOTHER'S MAIDEN NAME: Alice Roach
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: wife, Philomena Dolan — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Collapse, postoperative — 48 hours
DUE TO (b) Bronchogenic Carcinoma with extensive metastasis, unresectable — 6 months +
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1961 to Aug 16, 1961, that (I) (~~was~~) last saw the deceased alive on Aug 16 1961 and that death occured at 10:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: J. D. Peabody Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 16, 1961
22c. PHYSICIAN'S NAME (Type): J D. P eabody Jr.
22d. ADDRESS: 1150 Conn. Ave. Wash. D.C

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/19/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9278

CERTIFICATE OF DEATH

09269

M

I

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2901 Conn. Avenue, N . W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

A7X-3

3. NAME OF DECEASED (Type or print): First: Kathryn Middle: E Last: Dunkhorst

4. DATE OF DEATH Month: August Day: 14 Year: 19 61

5. SEX: Female **6. COLOR OR RACE:** White **7. MARITAL STATUS:** MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/2/1877

9. AGE (In years lost birthday): 83 yrs. IF UNDER 1 YEAR: Months 9 Days 12 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Dunkhorst
14. MOTHER'S MAIDEN NAME: Elizabeth Fuss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mrs. Dowell-Granddaughter-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bowel Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(b) CARCINOMA of Rectum — 2 yrs
DUE TO
(c)

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 28 1949 to Aug 14 1961, that (I) (we) last saw the deceased alive on Aug 13 1961, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE Horace H Custis M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8-14-61
22c. PHYSICIAN'S NAME (Type): Horace H. Custis, Jr.
22d. ADDRESS ~~1852~~ 1852 Columbia Road NW, Wash. D.C

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/17/61
23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cem.
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09270

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 37 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5601 Chillum Hgts Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1650-2

3. NAME OF DECEASED (Type or print): First: Bernard; Middle: Lewis; Last: Edwards Jr.
4. DATE OF DEATH: Month: 8; Day: 31; Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-30-18
9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Operator
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Government
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Bernard L. Edward Sr.
14. MOTHER'S MAIDEN NAME: Louise Elizabeth ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes. (If yes give war or date of service): W.W. II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ruby Sweatman - Sister in law — Address: Same Address -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/5/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country) (State): Arlington, Virginia
23. FUNERAL DIRECTOR: Malley's Funeral Home, Inc. — ADDRESS: Mt. Rainier, Md.
24a. REC'D BY REGISTRAR: SEP 7 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9280

CERTIFICATE OF DEATH

Reg. Dist. No. 09271

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 90 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Summit
d. STREET ADDRESS: 27 Sheffield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67 X-3

3. NAME OF DECEASED (Type or print): First: Roy; Middle: Reed; Last: Edwards
4. DATE OF DEATH: Month: August; Day: 22; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 10, 1927
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contracting Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Victor Edwards
14. MOTHER'S MAIDEN NAME: Lena Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 423-26-4747
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia with acute blastic crisis — INTERVAL BETWEEN ONSET AND DEATH: 6 years

204.0

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 24, 1961, to August 22, 1961, that I last saw the deceased alive on August 22, 1961, and that death occurred at 12:49P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geo. H. Porter M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED
PHYSICIAN'S NAME (Type): GEORGE H. PORTER, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 8/23/61
22c. NAME OF CEMETERY OR CREMATORY: Forest Hill Cemetery
22d. LOCATION (City, town, or county) (State): Birmingham, Alabama
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 28 61
24b. REGISTRAR'S SIGNATURE: Arthur L. Mauck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9281 — 09272

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union
d. STREET ADDRESS: 2051 Pleasant Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67X-3

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Robert — Last: Eskin

4. DATE OF DEATH: Month: August — Day: 13 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 25, 1941

9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Eskin

14. MOTHER'S MAIDEN NAME: Helen Eroncrantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1959 - 1960

16. SOCIAL SECURITY NO.: 138-32-7299

17. INFORMANT: The Medical Records, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myelogenous Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 21 months
DUE TO (b) Congestive Heart Failure — 2 days
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 28, 1961, to August 13, 1961, that (I) (we) last saw the deceased alive on August 13, 1961, and that death occured at 10:20 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Geo. H. Porter, III, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8/14/61

22c. PHYSICIAN'S NAME (Type): GEO. H. PORTER, III, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Trans

23b. DATE THEREOF: 8/14/61

23c. NAME OF CEMETERY OR CREMATORY: Hebrew Cemetery

23d. LOCATION (City, town or county) (State): Newark, New Jersey

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9282 — 09273

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 60 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Flushing
d. STREET ADDRESS: 141-49 70th Road, Kew Garden Hills
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin — Middle: Harold — Last: Ezrin
4. DATE OF DEATH: Month: August — Day: 12 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 28, 1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner
10b. KIND OF BUSINESS OR INDUSTRY: Business
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Max Ezrin
14. MOTHER'S MAIDEN NAME: Anna Zirlin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 051-14-1610
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac Arrhythmia & Acute Renal Shutdown — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b) Carcinoid Heart Disease — ? 1 year

DUE TO (c) Malignant Carcinoid with Hepatic & Peritoneal Metastasis — ? 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis & Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from June 13, 1961 to August 12, 1961, that ☒ (we) last saw the deceased alive on August 12, 1961, and that death occured at 1:10PM from the causes and on the date stated above.

22a. SIGNATURE: O. W. McBride — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/12/61
22c. PHYSICIAN'S NAME (Type): O. Wesley McBride, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Park
23d. LOCATION (City, town or county) (State): Paramus, New Jersey

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.
25a. ACCEPTED BY REGISTRAR — DATE: AUG 16 61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9283 — 09274

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 32 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY: 47 X 3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C.
d. STREET ADDRESS: 1500-MASS. AVE. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret, Middle A., Last Feldt
4. DATE OF DEATH: Month 8, Day 28, Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/1/90
9. AGE (In years lost birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife and Minister
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BUFFALO, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: MR. NAT. C. HODGDON — Address: 7501 HOLIDAY TERRACE, BETHESDA, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal Failure Heart failure
450.0
DUE TO (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post Prosthesis Right Hip (Subcapital Fracture)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fracture of Hip from Fall Wash DC
20c. TIME OF INJURY Month, Day, Year: April 21 1961 — Hour ~~a.m.~~ p.m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Wash DC (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 1951 to Aug 28 1961, that (I) (we) last saw the deceased alive on Aug 28 1961, and that death occurred at 12 p.m. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr I.S. Grisoff
22d. ADDRESS: 4500 Conn Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): cremation 8/31/61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City, town, or county) (State): Prince Georges, Md.
24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: AUG 30 '61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9284

CERTIFICATE OF DEATH

09275

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2½ YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 10808 BREEWOOD RD.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SILVER SPRING.
d. STREET ADDRESS: 10808 BREEWOOD RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle — Last FERRARA

4. DATE OF DEATH: Month AUGUST Day 10 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: APRIL 22, 1876

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LABORER

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY? 1st PAPERS, USA

13. FATHER'S NAME: GIUSEPPE FERRARA

14. MOTHER'S MAIDEN NAME: NOT KNOWN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NO

17. INFORMANT Address: ALEX FERRARA, 10808 BREEWOOD RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 2+ YRS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 2 2.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): "PLEURISY" — 5 WEEKS PREVIOUSLY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from AUG. 10, 1961, to AUG. 10, 1961, that (I) (~~we~~) last saw the deceased alive on AUG. 10, 1961, and that death occured at 5:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Gene U. Cohen M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: AUG. 10, 1961

22c. PHYSICIAN'S NAME (Type): GENE U. COHEN, M.D

22d. ADDRESS: 931 PERSHING DR., SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/14/61

23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery

23d. LOCATION (City, town or county) (State): Montgomery County, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Zisk ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue

25a. REC'D BY REGISTRAR DATE: AUG 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur E. Hiers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9285

CERTIFICATE OF DEATH

Reg. Dist. No. 09276

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — ~~Montgomery~~
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5915 Sonoma Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: W. — Last: FERRIN
4. DATE OF DEATH: Month: 8 — Day: 10 — Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/8/63
9. AGE (In years last birthday): 98 yrs. — IF UNDER 1 YEAR: Months: 3, Days: 0 — IF UNDER 24 HRS.: Hours: , Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: (Unknown) Ferrin
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-18-8580
17. INFORMANT: John A. Carlson — Address: Friend-same 2d

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): NATURAL CAUSES
DUE TO
(b): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/8, 1961, to 8/10, 1961, that I last saw the deceased alive on 8/9, 1961, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: I. L. Marks M.D. — ADDRESS (Street, city or town, state): 6306 Wisconsin Ave Chevy Chase 15, Md. — DATE SIGNED: 8/10/61

PHYSICIAN'S NAME (Type): I. L. MARKS

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8/16/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE AUG 18 '61
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9286 — 09277

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7606 Arnet Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 7606 Arnet Lane
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ROSE — Middle H. — Last FLINT
4. DATE OF DEATH: Month August — Day 28, — Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 6, 1883
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Newport, Rhode Island
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Joseph F. Howard
14. MOTHER'S MAIDEN NAME: Adelaide Kenworthy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: 1 — Address: John L. Hoen, sone-in-law-same 2d

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Accident (Minor Hemorrhage) — 4 days
DUE TO (b) Arteriosclerosis generalized — 10+ years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteoporosis — Carcinoma Cervix. Clinically X Ray.
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour ~~a.m.~~ p.m. ~~3 20 8/28/61~~ — Month, Day, Year
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 5, 1961, to 8/28/61, 19....., that (I) (we) last saw the deceased alive on 8/27 1961, and that death occured at 3:30 p.m., from the causes and on the date stated above.

22a. SIGNATURE: John B Markoky — M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 8-28-61
22c. PHYSICIAN'S NAME (Type): John B. Markoky
22d. ADDRESS: 4545 Conn. Ave., N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Trans
23b. DATE THEREOF: 8/30/61
23c. NAME OF CEMETERY OR CREMATORY: Swan Point Cemetery
23d. LOCATION (City, town or county) (State): Providence, Rhode Island

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE SEP 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9287

CERTIFICATE OF DEATH

09278

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium + Hosp
d. STREET ADDRESS: 3202 Kimberly Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: Elizabeth — Last: Fones
4. DATE OF DEATH: Month: 8 — Day: 15 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-3-24
9. AGE (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary + Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: J. H. Malseed
14. MOTHER'S MAIDEN NAME: Alice Borum.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service): None
16. SOCIAL SECURITY NO.: 577-26-4217
17. INFORMANT: Pr. and old Hosp. records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis + Insufficiency - Severe — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Bilateral Hydrothorax + Acites — 7 days

DUE TO (c) Carcinoma Breast right c generalized Carcinomatosis — about 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Apr. 7, 1961, to 8-15, 1961, that (I) (we) last saw the deceased alive on 8-15 1961, and that death occured at 9:15 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Read N. Calvert M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Read N. Calvert, M.D.
22d. ADDRESS: 909 Pershing Drive, Silver Spring Md

23a. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): 8/18/61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. Raymond H. Zska
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: AUG 21 61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9288

CERTIFICATE OF DEATH

09279

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5367 Blaine Street, N. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Benjamin; Middle: Jerome; Last: Fonville

4. DATE OF DEATH: Month: August; Day: 25; Year: 1961

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-4-13
9. AGE (In years last birthday): 47 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Analytic statistician
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin S. Fonville
14. MOTHER'S MAIDEN NAME: Lillian Holden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: (W) Mrs. Olga V. Fonville same as #2 above — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

201X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 20, 1961 to August 25 1961, that (I) (we) last saw the deceased alive on August 25 1961, and that death occured at 12:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: John W Brackett Jr M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 25, 1961
22c. PHYSICIAN'S NAME (Type): JOHN W. BRACKETT, JR. LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 29, 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington Va.

24. FUNERAL DIRECTOR'S SIGNATURE: John S Stewart
ADDRESS: Stewart Funeral Home, 30 H St. N.E., Washington, D.C.
25a. REC'D BY REGISTRAR DATE: AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 051 I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9289 — 09280

1 M 890 I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified and approved

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Ednor
c. LENGTH OF STAY IN 1b: Two months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Belmont Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 7001 - 31st Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-2

3. NAME OF DECEASED (Type or print): First / Middle / Last: Mary Elizabeth Foright

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 22, 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Hopkinsville, Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Edmonson
14. MOTHER'S MAIDEN NAME: Mary E. Thacker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Evelyn M. Shah — Address: 7001 - 31st Street N.W. Washington D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent (post operative) left breast carcinoma
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture right hip (6/61) with open reduction (uncomplicated)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/19, 1961 to 8/21, 1961, that (I) (we) last saw the deceased alive on 8/15, 1961 and that death occured at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John P. Martin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/21/61
22c. PHYSICIAN'S NAME (Type): JOHN P. MARTIN MD.
22d. ADDRESS: Sandyspring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Prince George's County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zirkel
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE AUG 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Hines

VR A15 (4) 15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9290 **CERTIFICATE OF DEATH** 09281

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 7906 Woodbury Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond; Middle: Clifton; Last: Freas, Sr.

4. DATE OF DEATH: Month: August; Day: 8; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-7-98
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months: ~~5~~ Days: ~~5~~ IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: self employed
11. BIRTHPLACE (County & State, or foreign country): Montgomery Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Allen Freas
14. MOTHER'S MAIDEN NAME: Elizabeth Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service): ----------
16. SOCIAL SECURITY NO.: 214-03-8610
17. INFORMANT: Mr. Raymond C. Freas, Jr. Address: 2936 Marlow Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): arterio-sclerosis
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/5, 1961, to 8/8, 1961, that (I) (we) last saw the deceased alive on 8/8 1961, and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: O. B. Little M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): A. B. LITTLE
22d. ADDRESS: 6911 5th St. NW. Wash. 12, DC

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/11/61
23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9291 — 09282

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont Gomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 719 Monroe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: GARGES

4. DATE OF DEATH: Month: August — Day: 10 — Year: 1961

5. SEX: Unknown

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-8-61

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Bethesda, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Tyler Garges

14. MOTHER'S MAIDEN NAME: Margaret Ann Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: (F) Daniel T. Garges same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE CONGENITAL ANOMALIES — INTERVAL BETWEEN ONSET AND DEATH
759.3
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from August 8, 1961 to August 10, 1961 that I (we) last saw the deceased alive on August 10 1961, and that death occured at 7:22 AM, from the causes and on the date stated above.

22a. SIGNATURE: James J. Ryskamp, Jr. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 10, 1961

22c. PHYSICIAN'S NAME (Type): JAMES J. RYSKAMP, JR. LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington Va

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler, Rockville, Md.
ADDRESS: Rockville

25a. REC'D BY REGISTRAR DATE: AUG 11 '61

25b. REGISTRAR'S SIGNATURE: Emma S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9292

CERTIFICATE OF DEATH

09283

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Scranton
d. STREET ADDRESS: 415 Arthur Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Francis — Last: Gibbons
4. DATE OF DEATH: Month: August — Day: 7 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 26, 1905
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: Accounting
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Gibbons
14. MOTHER'S MAIDEN NAME: Anna McGuire
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give year or dates of service)
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable Septicemia with hypotension — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): Renal Failure — 7 days

DUE TO (c): Acute leukemia — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2043

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from August 3, 1961 to August 7, 1961, that ☒ (we) last saw the deceased alive on August 7, 1961, and that death occured at 5:20PM, from the causes and on the date stated above.

22a. SIGNATURE: Robert H. Levin MD M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/7/61
22c. PHYSICIAN'S NAME (Type): Robert H. Levin, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 8-8-61
23c. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery
23d. LOCATION (City, town or county) (State): Scranton, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE AUG 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9293

CERTIFICATE OF DEATH

09284

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8018 Glendale Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 51 Chevy Chase
d. STREET ADDRESS: 8018 Glendale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LORETTO Middle S. Last GIBNEY

4. DATE OF DEATH: Month Aug. Day 30, Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 22, 1888

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months 9 Days 8 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mark L. Salamon=

14. MOTHER'S MAIDEN NAME: Mary Leddy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Lorraine G. Swagart-daughter-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 MINUTES

DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — 10 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): INVALID C MULTIPLE SCLEROSIS 18 YRS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 8, 1961, to Aug 30, 1961, that (I) (we) last saw the deceased alive on Aug 27 1961, and that death occured at 6:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: Leo I. Donovan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-30-61

22c. PHYSICIAN'S NAME (Type): LEO I. DONOVAN

22d. ADDRESS: 8218 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/2/61

23c. NAME OF CEMETERY OR CREMATORY: St. Agnes Cemetery

23d. LOCATION (City, town or county) (State): West Chester, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9294

CERTIFICATE OF DEATH

09285

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Binghamton
d. STREET ADDRESS: 27 Leroy Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

69X-2

3. NAME OF DECEASED (Type or print): First: Leo — Middle: Edward — Last: Gilroy

4. DATE OF DEATH: Month: August — Day: 10, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: February 8, 1911

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Optician

10b. KIND OF BUSINESS OR INDUSTRY: Office

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank P. Gilroy

14. MOTHER'S MAIDEN NAME: Eva P. Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 070-03-5348

17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left Ventricular Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b) Aquired Aortic Stenosis — 6 months
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

421.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 6, 1961, to August 10, 1961, that (I) (we) last saw the deceased alive on August 10, 1961, and that death occured at 6:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE Richard P. Anderson M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED 8/11/61

22c. PHYSICIAN'S NAME (Type): RICHARD P. ANDERSON, M.D.

22d. ADDRESS: The Clinical Center National Institutes Of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 8-11-61

23c. NAME OF CEMETERY OR CREMATORY: Chenango Valley Cem.

23d. LOCATION (City, town or county) (State): Broome County, New York

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: AUG 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur E. Hume

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9295 **CERTIFICATE OF DEATH** 09286

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 178 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bloomfield
d. STREET ADDRESS: 24 Hazelwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Agnes — Last: Grant

4. DATE OF DEATH: Month: August — Day: 24, — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 6, 1894
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard Maguire
14. MOTHER'S MAIDEN NAME: Margaret Kerwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 136-01-9906
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Widespread Staphlococcal Septicemia — 5 - 7 days

DUE TO

(b) Abdominal abscess associated with segmental necrosis of transverse colon — 5-7 days

DUE TO

(c) Recurrent pancreatitis — several months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Sjogrens Syndrome (years) Chronic Osteomyelitis, left femur (1½ yrs.)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from February 27, 1961, to August 24, 19 61 that (I) (we) last saw the deceased alive on August 24 19 61, and that death occured at 11:05 PM from the causes and on the date stated above.

22a. SIGNATURE: William T. Butler, M.D. — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/25/61
22c. PHYSICIAN'S NAME (Type): WILLIAM T. BUTLER, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/28/61
23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
23d. LOCATION (City, town or county) (State): North Arlington, N. J.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 30 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9296 **CERTIFICATE OF DEATH** 09287

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 hrs. 25 mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8516-Irvington Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle B Last GRIFFITH
4. DATE OF DEATH: Month 8 Day 27 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 9, 1907
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Admin. Assistant
10b. KIND OF BUSINESS OR INDUSTRY: Red Cross
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Benjamin Griffith
14. MOTHER'S MAIDEN NAME: Laura Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Cleo Griffith-wife-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Lung
DUE TO (b): c metastases to Kidney
DUE TO (c): Adrenals & Spleen

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5/15, 1961, to 8/27, 1961, that (I) (~~we~~) last saw the deceased alive on 8/27, 1961, and that death occured at 8:27 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. T. Joyce M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8/28/61
22c. PHYSICIAN'S NAME (Type): W. T. Joyce
22d. ADDRESS: 8106 Maple Ridge Rd. Beth. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/30/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 30 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9297 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09288

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 216 Wayne Place, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Virginia Middle: Lee Last: Harford
4. DATE OF DEATH: Month: August Day: 20 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 15, 1943
9. AGE (In years last birthday): 18 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harold Leroy ~~Harford~~ Werner
14. MOTHER'S MAIDEN NAME: Virginia Trail
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Shirley Fookes Address: 3872-9th St., S.E., Wash DC

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC TAMPONADE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
815X
DUE TO (b) TRAUMATIC LACERATION, AURICULAR APPENDAGE, RIGHT AND LEFT CARDIACA — SUDDEN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) AUTO ACCIDENT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto while riding in rear of motor cycle
20c. TIME OF INJURY Hour a.m. 2:30 pm Month, Day, Year 8-20 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street
20f. (City or town) Silver Spring (County) Montg (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/26/61
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem
22d. LOCATION (City, town, or country): Colmar Manor (State): Md

23. FUNERAL DIRECTOR: W.W. Chambers Co. ADDRESS: 517-11 97 St. SE. Wash D.C.
24a. REC'D BY REGISTRAR DATE: AUG 24 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9298 **CERTIFICATE OF DEATH** 09289

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 6918 Willow Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: Agustus; Last: Harrison
4. DATE OF DEATH: Month: 8; Day: 12; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-15-1883
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired W & J Sloan
10b. KIND OF BUSINESS OR INDUSTRY: Furniture Store
11. BIRTHPLACE (County & State, or foreign country): Not Known
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Harrison
14. MOTHER'S MAIDEN NAME: Alice Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 578-03-0935
17. INFORMANT: Joseph A. Hillebert, Address: 7510 Carroll Ave., Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Carcinoma of Stomach (Cardia) — 6 mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 1955 to Aug 12, 1961, that (I) (we) last saw the deceased alive on Aug 11 1961, and that death occured at 7:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James H. Whitaker M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-12-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 7717 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/14/61
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county) (State): Suitland Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Hause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9299 — 03290

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1823 P. St.N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aubrey — Middle: Elbert — Last: Haynes

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 1-2-95
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Lindsey Haynes
14. MOTHER'S MAIDEN NAME: Molly Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 263 16 2248
17. INFORMANT — Address: (W) Elizabeth M. Haynes, Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-respiratory cessation
DUE TO (b) congestive heart failure
DUE TO (c) rheumatic mitral stenosis and insuff.

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Laennec's cirrhosis c ascites.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from August 7, 1961, to August 21, 1961, that ~~I~~ (we) last saw the deceased alive on August 21 1961, and that death occured at 1:18 PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph H. Eusterman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 21 August 1961
22c. PHYSICIAN'S NAME (Type): JOSEPH H. EUSTERMAN, LT MC USN
22d. ADDRESS: NNMC U. S. Naval Hospital Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 23 August 1961
23c. NAME OF CEMETERY OR CREMATORY: Lee Funeral Home
23d. LOCATION (City, town or county) (State): Washington D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 4th & Mass. Washington, D. C.
25a. REC'D BY REGISTRAR — DATE: AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9300 **CERTIFICATE OF DEATH** 09291

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 344 Howard Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Maryland Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 344 Howard Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

09 1

3. NAME OF DECEASED (Type or print): First: Edwin Middle: D. Last: Henley

4. DATE OF DEATH Month: Aug. Day: 17, Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 19, 1892

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Supt. Public Works

10b. KIND OF BUSINESS OR INDUSTRY: Town of Rockville

11. BIRTHPLACE (County & State, or foreign country): Montgomery Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Henley

14. MOTHER'S MAIDEN NAME: Ohler Peddicord

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)

16. SOCIAL SECURITY NO.: 214-18-7218

17. INFORMANT: Beatrice L. Henley — Address: 344 Howard Avenue, Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: ONE WEEK
420.1
DUE TO
(b) CONGESTIVE HEART FAILURE — 8 MONTHS
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS — 20 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS - UREMIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Nov. 1957 to August 18, 1961, that (I) ~~(we)~~ last saw the deceased alive on August 16, 1961, and that death occured at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE Gordon S Rosenberger M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED August 17, 1961

22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger

22d. ADDRESS: 310 W. Montgomery Ave, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL, (Specify): Burial

23b. DATE THEREOF: 8/19/61

23c. NAME OF CEMETERY OR CREMATORY: Forest Oak

23d. LOCATION (City, town or county) (State): Gaithersburg, Montgomery Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331-E. Monta. Ave. Rockville, Md.

25a. RECD BY REGISTRAR DATE: AUG 21 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9303 **CERTIFICATE OF DEATH** 09292

1 M I

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WHEATON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 SILVER SPRING
d. STREET ADDRESS: 13407 SHERWOOD FOREST DR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Boyd — Middle: L. — Last: HENRY
4. DATE OF DEATH: Month: 8 — Day: 16 — Year: 19 61
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 31, 1889
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARTINSBURG W. VA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: DANIEL L. HENRY
14. MOTHER'S MAIDEN NAME: MARY MAC BEE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. MARJORIE HALL — Address: 13407 SHERWOOD FOREST DR.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN.
420.1
DUE TO (b) ARTERIOSCLEROSIS — 10 YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CEREBRO VASCULAR ACCIDENT
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/16, 19 61 to 8/16, 19 61 that (I) (we) last saw the deceased alive on 8/16 19 61, and that death occured at 1:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: Henry H. Stout M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/16/61
22c. PHYSICIAN'S NAME (Type): H.W. STOUT
22d. ADDRESS: 10011 GEORGIA AVE SILVER SPRING MD

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): BP
23b. DATE THEREOF: 8-19-61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland - Md

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 300 4th st NE Wash DC.
25a. REC'D BY REGISTRAR — DATE AUG 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9302 **CERTIFICATE OF DEATH** 09293

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 708 Philadelphia Avenue Cur-Lu Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 1656-2
d. STREET ADDRESS: 8106 TahonaDrive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: HERMAN Middle: L. Last: HERMANSON
4. DATE OF DEATH: Month: Aug Day: 1 Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/24/82
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Able, Finland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Herman L. Hermanson
14. MOTHER'S MAIDEN NAME: Katherine----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578-09-1663
17. INFORMANT: Address: Mrs. Lillian C. Donaldson same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Cerebral thrombosis c̄ R. hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): Generalized arteriosclerosis — several years
DUE TO
(c): Senility — " "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic pyelonephritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec., 1958 to Aug. 1, 1961, that (I) ~~(we)~~ last saw the deceased alive on Aug. 1, 1961, and that death occured at 2:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 1, 61
22c. PHYSICIAN'S NAME (Type): IRWIN I. YAGER M.D.
22d. ADDRESS: 3055-16th St. N.W., WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 8/4/61
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company ADDRESS: 2701 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: AUG 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9303 **CERTIFICATE OF DEATH** 09294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 050 I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X 23
d. STREET ADDRESS: 5818 Sherrier Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha Middle: Virginia Last: Hiley
4. DATE OF DEATH: Month: August Day: 4, Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 1, 1912
9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Robertson
14. MOTHER'S MAIDEN NAME: Clara Sheets
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unavailable
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

435.0

DUE TO (b) Prolonged anoxia and temporary cardiac arrest — 24 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Myasthenia gravis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 3, 1961, to August 4, 1961 that (I) (we) last saw the deceased alive on August 4, 1961, and that death occured at 7:32 PM from the causes and on the date stated above.

22a. SIGNATURE: Edward L. Eyerman M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/5/61
22c. PHYSICIAN'S NAME (Type): EDWARD L. EYERMAN, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/7/1961
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Bladensburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Son ADDRESS: 1756 Pa. Ave. NW, DC
25a. REC'D BY REGISTRAR DATE: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Esther S. Krause

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9304 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09295

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R-609 Norwood Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Rockville
d. STREET ADDRESS: R 609 Norwood Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elgar; Middle: Lenwood; Last: Holland
4. DATE OF DEATH: Month: Aug; Day: 13; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9-16-1918
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Clarence Holland
14. MOTHER'S MAIDEN NAME: Martha Nickens
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon Monoxide poising — INTERVAL BETWEEN ONSET AND DEATH: Found dead in auto
973.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Hose attached to exhaust entering into car
20c. TIME OF INJURY: Hour a.m. ? p.m. Month, Day, Year: 8-10 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Rockville (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 8-13-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/15/61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant
22d. LOCATION (City, town, or country): Norbeck, Md. (State)

23. FUNERAL DIRECTOR: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: AUG 23 61
DATE
24b. REGISTRAR'S SIGNATURE: Emma L. Fearne

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9305

CERTIFICATE OF DEATH

Item 14 File 0293 8/28/61 iwk

U3296

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Le Dean Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 19215 WENDELL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIAN Middle W. Last HOUCK

4. DATE OF DEATH: Month Aug Day 21 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB. 11, 1884
9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Portsmouth, New Hamp.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank W. Morgan
14. MOTHER'S MAIDEN NAME: Helen unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wm G. Houck Jr. Address: (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
331X
DUE TO (b) Senile Arteriosclerosis — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Apr 1958 to 21 Aug 1961, that (I) (we) last saw the deceased alive on 1 Aug 1961, and that death occurred at 4:15 M, from the causes and on the date stated above.

22a. SIGNATURE: G B Queen M.D. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 21 Aug 1961
22c. PHYSICIAN'S NAME (Type): G. B. QUEEN M.D
22d. ADDRESS: 7112 Willow Ave TAKOMA PARK, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 24. 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Prince Georges County. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St NW D.C.
25a. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

(over)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8/22/61

Dr. Frank J. Broschart, Dep. Med. Examiner notified and authorized Dr. G. B. Queen to sign certificate

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9306

CERTIFICATE OF DEATH

09297

1

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Triangle
d. STREET ADDRESS: 36 A Purvis Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Judy Lee James — Middle: — Last:
4. DATE OF DEATH — Month: August — Day: 10 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-4-40
9. AGE (In years last birthday): 20 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? USA

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13. FATHER'S NAME: Ernest Hymer
14. MOTHER'S MAIDEN NAME: Margaret Braun

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 514-40-1063
17. INFORMANT: (H) Jack "J" James — Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lymphoblastic leukemia, acute — INTERVAL BETWEEN ONSET AND DEATH: 10 months
204.3
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from July 31 1961 to August 10 1961, that ~~(I)~~ (we) last saw the deceased alive on August 10 1961, and that death occured at 8:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Lewis Ned Cahill M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 10, 1961
22c. PHYSICIAN'S NAME (Type): Lewis Ned Cahill, LCDR MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shippment
23b. DATE THEREOF: August 10, 1961
23c. NAME OF CEMETERY OR CREMATORY: Municiple Cemetery
23d. LOCATION (City, town or county): Bonner Springs — (State): Kansas

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler ADDRESS: Rockville, Md
Tyson Wheeler, Rockville, Md.
25a. REC'D BY REGISTRAR — DATE AUG 11 '61
25b. REGISTRAR'S SIGNATURE: Curtis S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9307 (05298)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 1561 33rd St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: Lobdell — Last: Jennings

4. DATE OF DEATH: Month: August — Day: 16 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: September 26, 1900

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (County & State, or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ralph Jennings

14. MOTHER'S MAIDEN NAME: Belle Hutchin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 577 26 6210

17. INFORMANT: Gloria Jennings — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma, Right Lung — INTERVAL BETWEEN ONSET AND DEATH: one month
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from July 23, 1961 to August 16, 1961, that I (we) last saw the deceased alive on August 16, 1961, and that death occured at 2:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: D. L. Kelley M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 16, 1961

22c. PHYSICIAN'S NAME (Type): D. L. KELLEY, LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 21, 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington Va.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. Wm. DeVol — DeVol 2224 Wisconsin Ave.N.W.Washington, D. C.

25a. REC'D BY REGISTRAR DATE AUG 21 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9308

CERTIFICATE OF DEATH

09299

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 810 Johnson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Emma — Last: Jennings
4. DATE OF DEATH: Month: August — Day: 10 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 28, 1899
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months 2, Days 12 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Telephone Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levi C. Gill
14. MOTHER'S MAIDEN NAME: Augusta E. Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Washington Sanitarium and Hospital

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — 3 days

332X

DUE TO (b) Acute Passive Congestion - Cardiac — 3 days

DUE TO (c) Hypostatic Pneumonia — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1960, to Aug. 10, 1961, that (I) (we) last saw the deceased alive on Aug 9 1961, and that death occured at 2 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Robert A. Hare M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 10, 61
22c. PHYSICIAN'S NAME (Type): Robert A. Hare MD
22d. ADDRESS: 7600 Carroll Ave., T.P. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/12/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Prince George's Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska — ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue
25a. REC'D BY REGISTRAR DATE: AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1) Leni C. Gill Augusta E. Wilson

No ---------- Washington Sanitarium and Hospital

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9309 **CERTIFICATE OF DEATH** 09300

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 30 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia
d. STREET ADDRESS: 419 Constitution Ave. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ira — Middle: Ellsworth — Last: Johnson

4. DATE OF DEATH: Month: August — Day: 22 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 8-27-02
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Projectionist
10b. KIND OF BUSINESS OR INDUSTRY: Highland Theater
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albanus Stevenson Tudor Johnson
14. MOTHER'S MAIDEN NAME: Edith Yoder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 216-09-9263
17. INFORMANT: Son-in Law — Address: UH 2-2290 13914 Parkland Dr. Rockville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10-15 mnts
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Collagen Disease.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/15 1960 to 8/22, 1961, that (I) (we) last saw the deceased alive on 8/22 1961, and that death occured at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W B Wardrop MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/23/61
22c. PHYSICIAN'S NAME (Type): W. B. WARDROP. M.D.
22d. ADDRESS: 800 Pershing Drive. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/25/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county): Washington, D.C. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Zisk
ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE AUG 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9310 **CERTIFICATE OF DEATH** 09301

1 5 M 050 I 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X-3
d. STREET ADDRESS: 14-A West Del Ray Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jewell; Middle: Gwendolyn; Last: Johnson

4. DATE OF DEATH: Month: August; Day: 21; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1918
9. AGE (In years on last birthday): 43
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reasearch analyst
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (County & State, or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur J. Johnson
14. MOTHER'S MAIDEN NAME: Georgia Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 468-12-4502
17. INFORMANT: The Medical Records, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural Hematoma — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
204.3
DUE TO
(b) Acute Myelogenous Leukemia — 10 Months
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 21, 1961, to August 21, 1961, that (I) (we) last saw the deceased alive on August 21, 1961, and that death occured at 4:32 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Robert H. Levin M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/22/61
22c. PHYSICIAN'S NAME (Type): ROBERT H. LEVIN, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: S H Hines Co. ADDRESS: 8901 14th St NW.
25a. REC'D BY REGISTRAR DATE: AUG 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9311 **CERTIFICATE OF DEATH** 09302

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. #1 Gaithersburg, Md
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ammons Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, Md
d. STREET ADDRESS: 211 Spring Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Garfield; Last: Johnson
4. DATE OF DEATH: Month: August; Day: 12; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/18/1903
9. AGE (In years lost birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Johnson
14. MOTHER'S MAIDEN NAME: Georgia Hayes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Kathleen Offutt (Daughter) — Address: Rockville, Md

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
DUE TO (b) C.V.A.
DUE TO (c) Hypertension

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7/5, 1961, to 8/12, 1961, that (I) (we) last saw the deceased alive on 8/11, 1961, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Luciano I. Leal — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Luciano I. Leal
22d. ADDRESS: Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/61
23c. NAME OF CEMETERY OR CREMATORY: Rocky Hill Cem
23d. LOCATION (City, town, or county) (State): Clarksburg, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR — DATE AUG 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Trant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9312 **CERTIFICATE OF DEATH** 09303

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Masontown
d. STREET ADDRESS: 539 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X-3

3. NAME OF DECEASED (Type or print): First: Albert — Middle: Jack — Last: Kermes

4. DATE OF DEATH: Month: August — Day: 9 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-16-28
9. AGE (In years last birthday): 32 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Albert John Kermes
14. MOTHER'S MAIDEN NAME: Rose Roth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 163-22-5705
17. INFORMANT: (W) Marilyn G. Kermes — Address: same as #2 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aortic stenosis — INTERVAL BETWEEN ONSET AND DEATH: undetermined

DUE TO (b) Rheumatic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

411X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from August 3, 1961 to August 9, 1961 that I (we) last saw the deceased alive on August 9 1961, and that death occured at 11:00 AM from the causes and on the date stated above.

22a. SIGNATURE: B H Rice M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 10, 1961
22c. PHYSICIAN'S NAME (Type): B. H. RICE, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 14.1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington (State): Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Robert A. Pumphrey, 7550 Wisconsin Ave, Bethesda, Md.
25a. REC'D BY REGISTRAR: DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9313 — 09304

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3335 - Military Rd., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: F. — Last: Keyser
4. DATE OF DEATH: Month: August — Day: 24, — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/5/1883
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Teacher
11. BIRTHPLACE (County & State, or foreign country): North Sutton, N. Hampshire
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Fred Keyser
14. MOTHER'S MAIDEN NAME: Grace Shattuck
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 577-12-7827
17. INFORMANT: Address: Charles H. Omo 5514 Cedar Pkwy. Ch. Ch., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 34 da
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-23, 1961 to 8-24, 1961 that (I) (~~we~~) last saw the deceased alive on 8-24 1961, and that death occured at 9 A M, from the causes and on the date stated above.

22a. SIGNATURE: Jonathan M. Williams M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/24/61
22c. PHYSICIAN'S NAME (Type): Jonathan Williams, M.D.
22d. ADDRESS: 1726 "M" Street, N.W. Washington D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/26/61
23c. NAME OF CEMETERY OR CREMATORY: Bowman's Chapel Cem.
23d. LOCATION (City, town or county) (State): Cassville, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Neale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9314 **CERTIFICATE OF DEATH** 09305

Item 2 Film 0293 8/22/61 mh

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: California / Maryland
b. COUNTY: ~~Prince George~~ Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville / Berkley
d. STREET ADDRESS: 78 San Mateo Rd. / Fairfax Mill Rd. / Point Branch Nursing Home
IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice Middle: Elizabeth Last: Kidder
4. DATE OF DEATH: Month: Aug. Day: 10 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-10-87
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Fred H. Schrieber
14. MOTHER'S MAIDEN NAME: Esther Wheat
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY INFARCT
450.0
DUE TO (b) EMBOLISM
DUE TO (c) GENERALIZED ATHEROSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs (approx)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BRONCHOPNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 31 JULY 1961, to 8-10, 1961, that (I) ~~(we)~~ last saw the deceased alive on 8-10 1961, and that death occured at 6:05 PM, from the causes and on the date stated above.

22a. SIGNATURE: Morrill C. Quinnam Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): MORRILL C. QUINNAM JR
22d. ADDRESS: 7600 CARROLL AVE. TAKOMA PARK

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 8/11/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters
ADDRESS: 254 Carroll St. N.W. Wash. DC
25a. REC'D BY REGISTRAR DATE AUG 11 '61
25b. REGISTRAR'S SIGNATURE: Cushing E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9315 — 09306

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Kentucky — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Anchorage
d. STREET ADDRESS: 55x-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Sebastian — Last: Kieren

4. DATE OF DEATH: Month: August — Day: 23 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-31-88

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Marine Corps

11. BIRTHPLACE (County & State, or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Conrad Kieren

14. MOTHER'S MAIDEN NAME: Marie Gagnon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 406 03 5280

17. INFORMANT — Address: (W) Josephine B. Kieren Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarct — 5 hrs.
DUE TO (b) Chronic emphysema — 2 yrs
DUE TO (c) Bronchogenic carcinoma, R lung, infiltrating — 3½ yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from July 15, 1961 to August 23, 1961 that I (we) last saw the deceased alive on August 23 1961, and that death occured at 9:50 PM from the causes and on the date stated above.

22a. SIGNATURE: D P Osborne — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 24, 1961

22c. PHYSICIAN'S NAME (Type): D. P. OSBORNE, CAPTAIN, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 28 August 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Robert A. Pumphrey, Bethesda, Md.

25a. REC'D BY REGISTRAR DATE AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

M

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9316 **CERTIFICATE OF DEATH** 09307

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: four days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3112 McComas Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

074

3. NAME OF DECEASED (Type or print): First: Mrs. Bertha Alice; Middle: ; Last: KIRK

4. DATE OF DEATH: Month: Aug; Day: 19; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1886

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Randolph County, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Addison Albred

14. MOTHER'S MAIDEN NAME: Rebecca Elizabeth Connor

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Robert F. Grant — Address: 3213 Greencastle Road, Burtonsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
420.0
DUE TO (b) Acute Congestive Heart Failure — 3 days
DUE TO (c) Arterio sclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 16, 1961, to Aug 19, 1961, that (I) (we) last saw the deceased alive on Aug 19, 1961, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 19, 1961

22c. PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D.

22d. ADDRESS: 10609 Concord Street, Kens., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/22/61

23c. NAME OF CEMETERY OR CREMATORY: Colesville Cemetery

23d. LOCATION (City, town, or county) (State): Colesville, Montgomery, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Barney E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9317 **CERTIFICATE OF DEATH** 09308

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park.
c. LENGTH OF STAY IN 1b: 1 day 14 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: District of Columbia
b. COUNTY: ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington 47 X-3
d. STREET ADDRESS: 1530 Rhode Island Ave. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie Middle: Jennings Last: Knight
4. DATE OF DEATH: Month: August Day: 17 Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 17, 1896
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard Force USA - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Willie J Knight
14. MOTHER'S MAIDEN NAME: Susie Belding
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): WW1 Army
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Hospital Chart Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO (b): Carcinoma of the lung. — 18 months
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1960 ~~19~~, to 8/16, 1961, that (I) ~~(we)~~ last saw the deceased alive on 8/16 1961, and that death occured at 4:55 A.M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Hugh W. Idey
22d. ADDRESS: 7105 Riggs Road, Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 8/19/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: 2901 - 14th St. N.W. Wash 9, D.C.
25a. REC'D BY REGISTRAR DATE AUG 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9318 — 09309

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jacksonville
d. STREET ADDRESS: 331 Eastwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Dean — Last: Kratzer
4. DATE OF DEATH: Month: August — Day: 7 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-20-61
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months 1, Days 18; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David Harrison Kratzer
14. MOTHER'S MAIDEN NAME: Loretta Torrente
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: David H. Kratzer — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital heart disease, (coarctation of aorta) — INTERVAL BETWEEN ONSET AND DEATH
754.6
DUE TO (b) //
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from ~~s~~ August 3 19 61 to August 7, 19 61, that ~~I~~ (we) last saw the deceased alive on August 7 19 61 and that death occured at 10:35 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-6-61
22c. PHYSICIAN'S NAME (Type): Robert V. Rack, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-11-61
23c. NAME OF CEMETERY OR CREMATORY: Haly Sepulchre
23d. LOCATION (City, town or county) (State): Philadelphia Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: R.A.Pumphrey, 7557 Wisconsin Ave. Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: AUG 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9319

CERTIFICATE OF DEATH

Reg. Dist. No. 09310

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1078 RUATAN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 1078-RUATAN, ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First SIMON Middle KUZMINSKY Last

4. DATE OF DEATH: Month AUG. Day 16 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: SEPT. 1895

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCER

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: AKIVA KUZMINSKY

14. MOTHER'S MAIDEN NAME: CHAYA —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-34-5096

INFORMANT: MORTON KIZHER Address: 1078 RUATAN ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

237 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 12, 1961, to Aug 16, 1961, that I last saw the deceased alive on Aug 15, 1961, and that death occurred at 10:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Morton Altschuler M.D. — ADDRESS (Street, city or town, state): 9205 New Hampshire — DATE SIGNED: 8/16/61

PHYSICIAN'S NAME (Type): Morton Altschuler, M.D. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUGUST 17, 1961

22c. NAME OF CEMETERY OR CREMATORY: MT. LEBANON CEMETERY

22d. LOCATION (City, town, or county) (State): HYATTSVILLE Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Dougherty & Sons — ADDRESS: 3501-14 St. NW

24a. REC'D BY REGISTRAR DATE: AUG 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9320 **CERTIFICATE OF DEATH** 09311

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Springfield
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5512 Pollard Rd.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
d. STREET ADDRESS: 5512 Pollard Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROGER; Middle A.; Last LaGUARDIA
4. DATE OF DEATH: Month Aug.; Day 5; Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1925
9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months 2, Days 13 IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Administrative Asst - Hospital
10b. KIND OF BUSINESS OR INDUSTRY: Georgetown
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Gari LaGuardia
14. MOTHER'S MAIDEN NAME: Francesca Sciommari
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 577-30-3188
17. INFORMANT: Barbara M. LaGuardia-wife-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b) Coronary Thrombosis — 2 hrs.
DUE TO (c) coronary arteriosclerosis — Indefinite

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 2, 19 54 to 8/5/, 1961, that (I) (we) last saw the deceased alive on 8/5/ 1961, and that death occured at [illegible] from the causes and on the date stated above.

22e. SIGNATURE: Stephen N. Jones MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/7/61
22c. PHYSICIAN'S NAME (Type): STEPHEN N. JONES
22d. ADDRESS: 809 Viers Mill Rd., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/9/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9321

Reg. Dist. No. 09312

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: Since 1937
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6901 Beechwood Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 6901 Beechwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Ers; Last: Lamb
4. DATE OF DEATH: Month: August; Day: 7; Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 1886
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney-ret.
10b. KIND OF BUSINESS OR INDUSTRY: Patent Atty.
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Francis A. Lamb
14. MOTHER'S MAIDEN NAME: Peheroh Ewin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Yes Unknown
17. INFORMANT: Bill Lamb-son-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CACHEXIA and Exhaustion	6 MO
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	CARCINOMA of the Sigmoid	5 YRS
DUE TO (c)		

153.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While of work ☐ Not while of work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB 28, 1949 to AUG 7, 1961, that I last saw the deceased alive on AUG 6, 1961, and that death occurred at 12:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Horace H. Custis M.D. — ADDRESS (Street, city or town, state): 1852 Columbia Rd NW — DATE SIGNED: 8/7/61

PHYSICIAN'S NAME (Type): HORACE H. CUSTIS JR — Washington DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8/7/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE AUG 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9322 **CERTIFICATE OF DEATH** 09313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sani. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: ~~Montgomery~~ Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 1657-2
d. STREET ADDRESS: 1133 Chickasaw Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First George, Middle Anthony, Last Lambas
4. DATE OF DEATH: Month Aug, Day 29, Year 1961
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/21/88
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant-Owner- etired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Anthony Lambas
14. MOTHER'S MAIDEN NAME: Anna Vlisidis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578001-8345
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5½ days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus & Arteriosclerotic Heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December, 1957 to Aug. 29, 1961, that (I) (~~we~~) last saw the deceased alive on Aug. 28, 1961, and that death occured at 10:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Russell B. Arnold M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.
22d. ADDRESS: 8801 Colesville Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 9/1/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: DATE SEP 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9323 **CERTIFICATE OF DEATH** 09314

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: Two years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1602 Dublin Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1602 Dublin Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD Middle JOHN Last LAVERY

4. DATE OF DEATH: Month 8 Day 2 Year 1961

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 20, 1877
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Claims Dept. Insurance Co.
11. BIRTHPLACE (County & State, or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Lavery
14. MOTHER'S MAIDEN NAME: Mary Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service): ----------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Emma G. Lavery Address: 1602 Dublin Drive, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — 10 YEARS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE — SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1958, to 8/2, 1961, that (I) (we) last saw the deceased alive on April 1961, and that death occured at 2:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Henry Stout M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/2/61
22c. PHYSICIAN'S NAME (Type): HENRY W. STOUT
22d. ADDRESS: 10,011 Georgia Avenue, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/4/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Montgomery County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeska
ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue
25a. REC'D BY REGISTRAR DATE AUG 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9324 Item 4 Film G293 8/28/61 jwk 09315

1. PLACE OF DEATH
a. COUNTY: Montg,
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rest Haven Rest Home
300 N. Frederick Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg. Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): John (First) Mills (Middle) Lawson (Last)
4. DATE OF DEATH: Month Aug 18 Day 14 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 5th 1886
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months 10 Days 9 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired. Auxter.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Lee's Burg. Va.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: John W. Lawson
14. MOTHER'S MAIDEN NAME: Rebecca Mills
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give year or dates of service)
16. SOCIAL SECURITY NO.: 213 16 2968
17. INFORMANT: Grace E. Partin. Address: Rockville. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
DUE TO (b) Carcinoma of Pancreas
DUE TO (c) Metastasis To bones of Pelvis

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1960, 19..., to 8/14, 19..., that (I) (we) last saw the deceased alive on 8/13 1961, and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Luciano I. Leal M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Luciano I. Leal
22d. ADDRESS: Gaithersburg. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-16-61
23c. NAME OF CEMETERY OR CREMATORY: Lake View
23d. LOCATION (City, town or county) (State): Hamilton. Va,

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ernest C. Gartner. Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9325 — 09316

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 500 Greenlawn Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1650-2

3. NAME OF DECEASED (Type or print): First: James — Middle: Ward — Last: Lawyer

4. DATE OF DEATH: Month: August — Day: 3 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov 19 - 1889

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Philip H. Lawyer

14. MOTHER'S MAIDEN NAME: Delilah Huttle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 hours.
420.0
DUE TO
(b) Arteriosclerotic heart disease — 2 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchitis, acute. Bronchiectasis. Emphysema.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1961, to Aug 3, 1961, that (I) (we) last saw the deceased alive on Aug 2 1961, and that death occured at 12:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Seruch T. Kimble, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3 Aug '61

22c. PHYSICIAN'S NAME (Type): Seruch T. Kimble

22d. ADDRESS: 927 Pershing Dr. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/5/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Gilbert C. Vincent

ADDRESS: 2525 Bladensburg Rd Wash DC

25a. REC'D BY REGISTRAR DATE AUG 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9326 **CERTIFICATE OF DEATH** 09317

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 3yr.10m.19days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Waverly Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westmorland Hills
d. STREET ADDRESS: 5314 Carvel Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nancy Middle: A. Last: Leatherwood
4. DATE OF DEATH: Month: August Day: 31 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-18-1872
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Henry Albaugh
14. MOTHER'S MAIDEN NAME: Mary Longnecker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Louis P. Allwine, Address: Waverley Sanitarium

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal hemorrhage, severe — INTERVAL BETWEEN ONSET AND DEATH: 15 mon
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Suspected growth in intestines — 1 yr.

236 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Jan 1955 to 31 Aug 1961 that (I) (~~saw~~) last saw the deceased alive on 28 July 1961, and that death occured at 11:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Herbert Martyn Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 31 Aug 61
22c. PHYSICIAN'S NAME (Type): HERBERT MARTYN JR
22d. ADDRESS: 5029 BETHESDA AVE. BETH Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 9-6-1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Salt Lake City, Utah
24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Lawler & Sons, Inc. ADDRESS: 1756 Pa. Ave. N.W. Wash. 6, D.C.
25a. REC'D BY REGISTRAR DATE: SEP 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9327

CERTIFICATE OF DEATH

09318

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1555 Fort Dupont St. N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 x 3

051

3. NAME OF DECEASED (Type or print): First: Landreville; Middle:; Last: LeDoux

4. DATE OF DEATH: Month: August; Day: 13; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-22-98

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Marine Corp

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Onesime LeDoux

14. MOTHER'S MAIDEN NAME: Ida M. Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Bertha T. LeDoux — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Coma
DUE TO (b): Cirrhosis Liver, Laennec's Type
DUE TO (c):

581.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from July 31, 1961 to August 13 1961 that I (we) last saw the deceased alive on August 13 1961, and that death occured at 8:50 PM from the causes and on the date stated above.

22a. SIGNATURE: John M. Lewis LCDR, MC, USN

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 14, 1961

22c. PHYSICIAN'S NAME (Type): JOHN M. LEWIS, LCDR MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 17,1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county): Arlington (State): Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home, Inc. 4th and Mass, N.E.

ADDRESS: Washington, D. C.

25a. FILED BY REGISTRAR: AUG 16 61 — DATE

25b. REGISTRAR'S SIGNATURE: Arthur S. Hanks

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9328 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09319

Item 9 Film G292 8/10/61 1wk Items 8, 9, & 14 G292 8/28/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Woodley Gardens Offic Bldg.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Md 1wk
b. COUNTY: Mont 45
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9310 Burning Tree Rd 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Girard; Last: Lee
4. DATE OF DEATH: Month: Aug; Day: 1; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-10-1908
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office manager
10b. KIND OF BUSINESS OR INDUSTRY: Const. Co.
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Walter H. Lee
14. MOTHER'S MAIDEN NAME: Sarah W. Washington
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): 577-09-8181 214-36-2777
17. INFORMANT: T. Girard Lee, Jr. (Son) — Address: 4869 Battery La Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Termination of Brain Stem — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Intraventricular cerebral hemorrhage — Sudden
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 8-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/4/61
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or country) (State): Rockville, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 7 '61
24b. REGISTRAR'S SIGNATURE: Clothier S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9329

Reg. Dist. No. 09320

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Waverly Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington DC 47X-3
d. STREET ADDRESS: 5415 Conn Ave N W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Goodrich Middle W Last Lineweaver
4. DATE OF DEATH: Month Aug Day 8 Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Jan. 4, 1887
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months 7 Days 4 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Consultant
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Madison
14. MOTHER'S MAIDEN NAME: Sally Ralston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: Unknown
INFORMANT: Mr. Croke-son in law-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 Mo
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) Essential Hypertension — 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 28, 1957, to Aug 8, 1961, that I last saw the deceased alive on Aug 6, 1961, and that death occurred at 630 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Herbert Bauersfeld M.D. — ADDRESS (Street, city or town, state): 1912 R St NW Wash DC — DATE SIGNED: 8/9/61

PHYSICIAN'S NAME (Type): E. Herbert Bauersfeld M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/11/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 14 61
24b. REGISTRAR'S SIGNATURE: Arthur L. Moore

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9330 **CERTIFICATE OF DEATH** 09321

1

M

051

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2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: South Carolina
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Spartanburg
d. STREET ADDRESS: 1063 Boiling Springs Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Timothy — Middle: Clark — Last: Lister

4. DATE OF DEATH: Month: August — Day: 3 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 11, 1960

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 11 — Days: 22
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Japan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Marchant Lister

14. MOTHER'S MAIDEN NAME: Evelyn Elizabeth Kimbrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert M. Lister — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tetanus of Fallot
754.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 19, 1961 to August 3, 1961, that (I) (we) last saw the deceased alive on August 3, 1961, and that death occured at 12:07 PM, from the causes and on the date stated above.

22a. SIGNATURE: R. P. Dobbie Jr. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): R.P. DOBBIE, JR. CDR MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial - Shippment

23b. DATE THEREOF: 4 August 1961

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City, town or county): Spartanburg (State): S. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Michael A. Rinaldi Jr.
ADDRESS: Rinaldi's Funeral Home, Washington, D. C.

25a. REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

9 VVV VVV XVV

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9331

CERTIFICATE OF DEATH

09322

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 days.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Bethesda
d. STREET ADDRESS: 7809 Tilbury St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mercedes; Middle: L.; Last: Little
4. DATE OF DEATH: Month: August; Day: 7; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 24 1878
9. AGE (If years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Paris, France
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph P. Sagrario
14. MOTHER'S MAIDEN NAME: Josephine Bileau
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-30-3403
17. INFORMANT: Sister (Marguerite Hogsgaard) Address: Same as above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
(a) 331X Confluent bronchopneumonia — 5 days
DUE TO
(b) Cerebrovascular Accident — 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 1, 1961, to Aug 7, 1961, that (I) (we) last saw the deceased alive on Aug 7 1961, and that death occured at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Dr Joseph Kenrick M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 7, 1961
22c. PHYSICIAN'S NAME (Type): Dr JOSEPH KENRICK
22d. ADDRESS: 6450 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-10-61
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Hurd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9332 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09323

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington San + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Pennsylvania
b. COUNTY Centre ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~State College~~ BOALSBURG
d. STREET ADDRESS KENNARD ROAD Rt 1 Box 457-I
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Jesse Middle Elsmer Last Livingston
4. DATE OF DEATH Month 8 Day 15 Year 1961

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-3-09
9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) University Professor
10b. KIND OF BUSINESS OR INDUSTRY Head of Dept.
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Cyrus L. Livingston
14. MOTHER'S MAIDEN NAME ELIZABETH ? Spangler -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) —
16. SOCIAL SECURITY NO. 506-264578
17. INFORMANT Mr. William D. Bell - Mrs. Una May Livingston - wife Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion
INTERVAL BETWEEN ONSET AND DEATH sudden
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) FRANK J. BROSCHART
Address (Street, city, town, or county)
DATE SIGNED 8-15-61

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 8/19/61
22c. NAME OF CEMETERY OR CREMATORY Center County Memorial Park
22d. LOCATION (City, town, or country) (State) Center County, Pennsylvania

23. FUNERAL DIRECTOR Raymond A. Ziska
Warner E. Pumphrey Inc.
ADDRESS 8434 Georgia Avenue
Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE AUG 17 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

1-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9333

CERTIFICATE OF DEATH

Reg. Dist. No. 09324

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 703 Gail Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 703 Gail Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LAURA Middle: (NMI) Last: LIVINGSTON
4. DATE OF DEATH: Month: August Day: 17, Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 16, 1877
9. AGE (In years lost birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: James D. Berry
14. MOTHER'S MAIDEN NAME: Mary Duncan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Maud Livingston-Item # 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days
420.1
DUE TO
(b): Arteriosclerosis, generalized — ? years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 17, 1955, to Aug. 17, 1961, that I last saw the deceased alive on Aug. 10, 1961, and that death occurred at 8:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Bowditch Hunter, M.D. — ADDRESS (Street, city or town, state): 809 Veirs Mill Rd — DATE SIGNED: 8/17/61

PHYSICIAN'S NAME (Type): G. Bowditch Hunter, Jr. Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 8/18/61
22c. NAME OF CEMETERY OR CREMATORY: Hickory Point
22d. LOCATION (City, town, or county) (State): Iberia, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montgomery Ave Rockville, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 21 '61
24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M X I

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9334 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09325

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 220 Park Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 220 Park Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ~~Jessie~~ Jessie Middle F. Last Lockwood

4. DATE OF DEATH Month Aug. Day 26 Year 1961

5. SEX female
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7/26/1871
9. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Not Available
14. MOTHER'S MAIDEN NAME Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Olivia McMahon Address 6323 McComb St., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH sudden

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8/26/61
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Aug. 28, 1961
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery
22d. LOCATION (City, town, or country) Washington, (State) D.C.

23. FUNERAL DIRECTOR J. Arthur Walters, ADDRESS 254 Carroll St NW DC
24a. REC'D BY REGISTRAR DATE AUG 29 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9335

CERTIFICATE OF DEATH

09326

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 806½ Parkwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

D210-2

3. NAME OF DECEASED (Type or print): First: Tammie; Middle: Lynn; Last: LOUVIERE
4. DATE OF DEATH: Month: August; Day: 2; Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-16-61
9. AGE (In years last birthday): ___ yrs. IF UNDER 1 YEAR: Months: ; Days: 17 IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Leo Paul Louviere
14. MOTHER'S MAIDEN NAME: Dianna Lou Mayard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leo Paul Louviere Address: Same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningitis — INTERVAL BETWEEN ONSET AND DEATH: 18 hours
DUE TO (b) meningomyelocele
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

751X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from July 17, 19 61 to August 2, 19 61, that I (we) last saw the deceased alive on August 2 19 61, and that death occured at 7:45 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 2, 1961
22c. PHYSICIAN'S NAME (Type): ROBERT V. RACK, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial - Shippment
23b. DATE THEREOF: 8-3-61
23c. NAME OF CEMETERY OR CREMATORY: Broussard Cemetery
23d. LOCATION (City, town or county): New Iberia (State): Louisiana

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Funeral Home
ADDRESS: 31st and M St. N. W. Washington, D. C.
25a. REC'D BY REGISTRAR DATE: AUG 4 '61
25b. REGISTRAR'S SIGNATURE: Cornelius S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Maryland

Bethesda (funeral) 10 days Annapolis

U. S. Naval Hospital Long Fairwood Ave.

Tamie Lynn LOUVINEE August 2 61

x

Female Caucasian 7-18-61 W

Infant Maryland Mr.

Leo Paul Lovitore Dianne Lou Layard

10 Le. Paul Lovitore Same as 2 above

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9336

CERTIFICATE OF DEATH

Reg. Dist. No. 09327

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12126 Viers Mill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orlando
d. STREET ADDRESS: Route #2, Box 488 (Maitland)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LENORE Middle P. Last LUSH
4. DATE OF DEATH: Month Aug. Day 15 Year 1961
5. SEX: Fe
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 5, 1889
9. AGE (In years lost birthday): 72 yrs.
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Roscoe M. Harlan
14. MOTHER'S MAIDEN NAME: Etta Blanche Boughton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Stephen L. Lush, 12126 Viers Mill Rd. S.S. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of breast — INTERVAL BETWEEN ONSET AND DEATH: 8 years
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cancer in axillary glands; also in r. femur (?)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1961, to Aug. 15, 1961, that I last saw the deceased alive on Aug 14, 1961, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: John N. Andrews M.D. — ADDRESS (Street, city or town, state): 9601 Colesville Rd — DATE SIGNED: 8-15-61
PHYSICIAN'S NAME (Type): John N. Andrews — Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 17, 1961
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. Arthur Walters, 254 Carroll St NW. DC
24a. REC'D BY REGISTRAR DATE: AUG 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur J. Riggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9337

CERTIFICATE OF DEATH

09328

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

051

16X-2

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 3216 Toledo Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: Carl — Last: LUTZ
4. DATE OF DEATH: Month: AUGUST — Day: 5 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-8-76
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William F. LUTZ
14. MOTHER'S MAIDEN NAME: Blandie PFILE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: Richard L. LUTZ, Address: 6709 Bradley Blvd, Bethesda, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Retroperitoneal hemorrhage
DUE TO (b) Ruptured aortic abdominal aneurysm
DUE TO (c) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-4- , 1961 to 8-5- , 1961, that (I) (we) last saw the deceased alive on 8-5- 1961, and that death occured at 9:18AM from the causes and on the date stated above.

22a. SIGNATURE: Joseph H. Eusterman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-5-61
22c. PHYSICIAN'S NAME (Type): Joseph H. EUSTERMAN, LT, MC, USN
22d. ADDRESS: U.S. NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 8. 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Gasch Funeral — ADDRESS: GASCH FUNERAL HOME, 4739 Balt. Ave. Hyattsville, Md.
25a. REC'D BY REGISTRAR: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

M

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9333

CERTIFICATE OF DEATH

09329

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

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1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 11 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4202 Dahill Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4202 Dahill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: Hamilton Last: MacDougal
4. DATE OF DEATH: Month: AUG. Day: 26 Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 28, 1888
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store
11. BIRTHPLACE (County & State, or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James H. Mac Dougal
14. MOTHER'S MAIDEN NAME: Annetta Russ
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 408-07-6210
17. INFORMANT: Mrs. Edith G. MacDougal Address: same (wife)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchiogenic Cancer — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO (b): Metastases to Bones — 2 months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 10 1961 to Aug 26 1961 that (I) (we) last saw the deceased alive on Aug 26 1961, and that death occured at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John J. Curry M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/26/61
22c. PHYSICIAN'S NAME (Type): John J. Curry
22d. ADDRESS: 10,620 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 28, 1961
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Montgomery County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
ADDRESS: Warner E. Pumphrey, Inc., Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Esther L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9339 **CERTIFICATE OF DEATH** 09330

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — Maryland — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: 14 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3518 NIMITZ ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3518 Nimitz Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Franklin — Middle: BONAVENTURE — Last: Mades
4. DATE OF DEATH: Month: August — Day: 16, — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 29, Novemeber 1918
9. AGE (In years lost birthday): 42 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): I.B.M. Operator
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Franklin D. Mades
14. MOTHER'S MAIDEN NAME: Sarah G. Ray
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW2
16. SOCIAL SECURITY NO.: 577-24-2736
17. INFORMANT: Mrs. Mary E. Mades — Address: 3518 Nimitz Road Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
DUE TO
(b) Acute congestive heart failure — 4 hours
DUE TO
(c) Hypertensive cardiovascular renal disease — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus; hepatic cirrhosis; ethanolism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/25 1961, to 8/10 1961, that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at 4 PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph D. Connor, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 16, 1961
22c. PHYSICIAN'S NAME (Type): Joseph D. Connor, M.D.
22d. ADDRESS: 9420 Old Georgetown Road, Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/19/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Prince Georges County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond R. Zisler — ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE: AUG 21 61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hawes

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9340 **CERTIFICATE OF DEATH** 09331

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1819 Lamont Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Emilia Antonia; Middle: ; Last: Maresta

4. DATE OF DEATH: Month: August; Day: 21; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-26-16

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Argentina

12. CITIZEN OF WHAT COUNTRY?: Argentina

13. FATHER'S NAME: Pedro Nataloni

14. MOTHER'S MAIDEN NAME: Gilda Gervont

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: (H) Antonio Maresta Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Metastasis
DUE TO (b): Carcinoma of Breast
DUE TO (c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from August 3, 1961 to August 21, 1961, that I (we) last saw the deceased alive on August 21, 1961, and that death occured at 8:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: W. F. Warrender M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: August 21, 1961

22c. PHYSICIAN'S NAME (Type): W. F. WARRENDER, LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 22 August 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: S. H. HINES-CO. — ADDRESS: S. H. Hines, 2901 14th St.N.W.Washington,D. C.

25a. REC'D BY REGISTRAR — DATE: AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9341

CERTIFICATE OF DEATH

09332

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5½ days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5803 Melvern Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: H — Last: Martyn

4. DATE OF DEATH: Month: August — Day: 10 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 4 1887
9. AGE (In years lost birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Navy Yard
11. BIRTHPLACE (State or foreign country): Washington DC.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Martyn
14. MOTHER'S MAIDEN NAME: Jane Minnis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (Florence Martyn) wife — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Gastric Contents — INTERVAL BETWEEN ONSET AND DEATH: 1 h
560.9
DUE TO (b): Intestinal obstruction — 36 h
DUE TO (c): bilateral inguinal hernia — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1961, to Aug 1961, that (I) (we) last saw the deceased alive on 8-10 1961, and that death occurred at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: Philip R. James M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/10/61
22c. PHYSICIAN'S NAME (Type): Philip R. James
22d. ADDRESS: Washington Clinic, Wash. D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/14/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 16 61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09333

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2200 Evans Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: V — Last: McCarthy
4. DATE OF DEATH: Month: Aug — Day: 25 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 28. 1912
9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sale Representative
10b. KIND OF BUSINESS OR INDUSTRY: Daniel Creed & Co.
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: John W. McCARTHY
14. MOTHER'S MAIDEN NAME: ~~[illegible]~~ BRIDGET T. REED.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-20-1709
17. INFORMANT: Mrs. Jean McCarthy — Address: 2200 Evans Drive Silver Spring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	acute left Congestive Heart failure	3 Hours
DUE TO (b)	Coronary Thrombosis	5 weeks
DUE TO (c)	Hypertensive Cardiovascular disease	3 yrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/21, 1961, to 8/25, 1961, that (I) (we) last saw the deceased alive on 8/25 1961, and that death occured at 2.20 PM, from the causes and on the date stated above.

22a. SIGNATURE: Henry Stout M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): H. W. STOUT MD
22d. ADDRESS: 10011 GEORGIA AVE SILVER SPRING MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-28-61
23c. NAME OF CEMETERY OR CREMATORY: GATE-OF-HEAVEN
23d. LOCATION (City, town or county) (State): MONTGOMERY COUNTY, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins — ADDRESS: 3821-14th St. N.W.
25a. RECEIVED BY REGISTRAR: AUG 29 61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur P. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9343

CERTIFICATE OF DEATH

09334

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colonial Beach
d. STREET ADDRESS: 524 Lafayette St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earl; Middle: Edward; Last: McCartney
4. DATE OF DEATH: Month: August; Day: 11; Year: 1961

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-12-89
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Armed Forces
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy
11. BIRTHPLACE (County & State, or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank McCartney
14. MOTHER'S MAIDEN NAME: Thurza M. Treadway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give wars or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from July 13, 1961 to August 11, 1961, that ☒ (we) last saw the deceased alive on August 11, 1961, and that death occured at 2:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: Paul G. Linaweaver LCDR MC USN
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 11, 1961
22c. PHYSICIAN'S NAME (Type): PAUL G. Linaweaver, LCDR MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 14, 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington (State): Va

24. FUNERAL DIRECTOR'S SIGNATURE: For Jerome L. Shaw
ADDRESS: Nash and Slaw Funeral Home, Colonial Beach, Va.
25a. RECD BY REGISTRAR DATE: AUG 16 61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Care should be taken by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9344

CERTIFICATE OF DEATH

09335

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 15 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 207 Sycamore Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

0210-2

3. NAME OF DECEASED (Type or print): First: Cynthia — Middle: Ann — Last: McCoy
4. DATE OF DEATH: Month: August — Day: 22 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-25-61
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 58 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Lonnie Joe McCoy
14. MOTHER'S MAIDEN NAME: Patsy Ruth Oliver
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Lonnie Joe McCoy Same as # 2 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Total anamolous pulmonary venous drainage
DUE TO
(b) Congenital heart disease
DUE TO
(c)

754.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 7, 1961 to August 22, 1961, that (I) (we) last saw the deceased alive on August 22 1961, and that death occured at 10:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: A. McClenathan M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 22, 1961
22c. PHYSICIAN'S NAME (Type): J. E. McClenathan, CDR MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial- shippment 23 August 1961
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Beulah Church Cemetery
23d. LOCATION (City, town or county): Albertville (State): Ala.

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler
ADDRESS: 1331 East Mont. ave.
Tyson Wheeler, Rockville, Md.

25a. REC'D BY REGISTRAR
DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

205122 XV5

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9345 **CERTIFICATE OF DEATH** 09336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Broadway
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

70X-3

3. NAME OF DECEASED (Type or print): First: Luverta; Middle: (None); Last: McDougald
4. DATE OF DEATH: Month: August; Day: 7; Year: 1961
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 1, 1928
9. AGE (In years last birthday): 33 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Adolph Amerson
14. MOTHER'S MAIDEN NAME: Odessett Strange
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record (Name) The Clinical Center, Bethesda 14, Maryland (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

174X

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Choriocarcinoma with metastases to lung, liver, gastrointestinal tract, pancreas, skin & muscle	9 months
DUE TO (b)	Gastrointestinal bleeding secondary to metastases	6 months
DUE TO (c)	Bloody pericardial effusion	Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Thyrotoxicosis by clinical history

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 14, 1961 to August 7, 1961 that (I) (we) last saw the deceased alive on August 7 1961, and that death occured at 9:55 PM from the causes and on the date stated above.

22a. SIGNATURE: M. A. Kirschner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 8/9/61
22c. PHYSICIAN'S NAME (Type): M. A. KIRSCHNER, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 8-10-61
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town or county): Broadway (State): N.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Frazier's Funeral Home Inc ADDRESS: 389-R. Law
25a. REC'D BY REGISTRAR DATE: AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Thomas

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9346 — 09337

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sherrill
d. STREET ADDRESS: 434 Kinsley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 050 I

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: Ann — Last: McQuade

4. DATE OF DEATH: Month: August — Day: 10, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 11, 1951

9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leonard L. McQuade

14. MOTHER'S MAIDEN NAME: Janette Crandell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give year or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b): Cystic Fibrosis — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

587.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 6, 1961 to August 10, 1961, that (I) (we) last saw the deceased alive on August 10, 1961, and that death occured at 3:02AM from the causes and on the date stated above.

22a. SIGNATURE: Gerald F. Powell M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8/10/61

22c. PHYSICIAN'S NAME (Type): GERALD F. POWELL, MD

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-transit

23b. DATE THEREOF: 8/11/1961

23c. NAME OF CEMETERY OR CREMATORY: Valley View,

23d. LOCATION (City, town or county) (State): Oneida New York

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25e. REC'D BY REGISTRAR — DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9347 — 09338

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3307 Oberon Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3307 Oberon Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jean — Middle: Gould — Last: Menefee

4. DATE OF DEATH: Month: August — Day: 3 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/28/64
9. AGE (In years last birthday): 96 yrs. — IF UNDER 1 YEAR: Months 8, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Gould
14. MOTHER'S MAIDEN NAME: Amelia Mege

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Jean Sartwell-daughter-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b) arteriosclerotic-renal disease — years
DUE TO (c) arterio sclerosis generalized — "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from March, 1961, to August 3, 1961, that (I) (we) last saw the deceased alive on August 1 1961, and that death occured at 5.20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Alfred S. Norton M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Alfred S. Norton, M.D.
22d. ADDRESS: 4711 Highland Ave., Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/5/61
23c. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9348

CERTIFICATE OF DEATH

09339

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: seven years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 303 Ladson Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 303 Ladson Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis; Middle: Edwin; Last: Metcalf

4. DATE OF DEATH: Month: August; Day: 8; Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 13, 1905

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CafeXteria Manager

10b. KIND OF BUSINESS OR INDUSTRY: Food Services

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank John son

14. MOTHER'S MAIDEN NAME: Virginia Clabaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 214-03-8683

17. INFORMANT: Mrs. Elizabeth P. Metcalf Address: 303 Ladson Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b) arteriosclerotic heart disease

DUE TO (c) Generalized arteriosclerosis — SEVERAL YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Aug 8 1961, that (I) (we) last saw the deceased alive on Aug 1 1961, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: M.F. Ottman M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/9/61

22c. PHYSICIAN'S NAME (Type): M.F. OTTMAN

22d. ADDRESS: 11800 Sa Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: AUG.9,1961

23c. NAME OF CEMETERY OR CREMATORY: TO GEORGE WASHINGTON MEDICAL SCHOOL, WASHINGTON,D.C.

23d. LOCATION (City, town, or county) (State): FOR MEDICAL RESEARCH.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. ZISKA. ADDRESS: WARNER E. PUMPHREY,INC.,SILVER SPRING,MD.

25a. REC'D BY REGISTRAR DATE: AUG 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

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M

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9349

CERTIFICATE OF DEATH

09340

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1yr- 10mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1743 Irving Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

4 7 X - 3

3. NAME OF DECEASED (Type or print): First: Bertha; Middle: W.; Last: Meyer

4. DATE OF DEATH: Month: August; Day: 22; Year: 1961

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9, 1872

9. AGE (In years lost birthday): 88 yrs. IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wilhelm Timm

14. MOTHER'S MAIDEN NAME: Johanna Bach.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William J. Meyer, 3621 S St. N.W. Address: Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bowel Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
450.0
DUE TO (b) Generalized Arteriosclerosis — 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Aug 22 1961, that (I) (we) last saw the deceased alive on Aug 21 1961, and that death occurred at 1:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James M. Williams MD M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-22-61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-24-1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons
ADDRESS: 1756 Pa. Ave. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE AUG 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9350 — 09341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 68 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21
d. STREET ADDRESS: 320 Popular Road — 03 X-2
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Melvin — Middle: Alexander — Last: Michaelkiewicz
4. DATE OF DEATH: Month: August — Day: 7 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 11-1-26
9. AGE (In years last birthday): 34 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Armed Forces
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Michaelkiewicz
14. MOTHER'S MAIDEN NAME: Eve Patro
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 214-20-0168
17. INFORMANT: Ruth Michaelkiewicz — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) diffuse, metastatic neuroblastoma — INTERVAL BETWEEN ONSET AND DEATH
193.4
DUE TO (b) neuroblastoma 1° in rt. sciatic nerve — 2 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from May 30, 1961 to August 7, 1961 that I (we) last saw the deceased alive on August 7 1961 and that death occured at 9:25 AM from the causes and on the date stated above.

22a. SIGNATURE: B H Rice, M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: August 7, 1961
22c. PHYSICIAN'S NAME (Type): B. H. RICE, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 11, 1961
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City, town or county): Baltimore — (State): Md
24. FUNERAL DIRECTOR'S SIGNATURE: Wm. Cook, Inc. — ADDRESS: St. Paul and Preston St. Baltimore, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

M

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9351

CERTIFICATE OF DEATH

09342

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 hours 55 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 304 Southwest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadie — Middle: Lelia — Last: Milam

4. DATE OF DEATH: Month: August — Day: 28 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 29, 1881

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Archer Tatum

14. MOTHER'S MAIDEN NAME: Mollie Tribble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Washington Sanitarium + Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Cerebral thrombosis with left hemiplegia — 4 wks
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

3334

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1961, to August 28, 1961, that (I) (we) last saw the deceased alive on August 28 1961, and that death occured at 10:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 28, 1961

22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., M.D.

22d. ADDRESS: 9301 Colesville Rd., Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): SHIP. R.R.

23b. DATE THEREOF: 8-29-61

23c. NAME OF CEMETERY OR CREMATORY: PEA RIDGE CEMETERY

23d. LOCATION (City, town or county): GRENADA (State): MISS

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers — ADDRESS: 1400 Chapin St., N. W. Wash. 9, D.C.

25a. REC'D BY REGISTRAR DATE: AUG 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9352

Reg. Dist. No. 09343

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4503 Renn Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 32
d. STREET ADDRESS: 4503 Renn Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: May — Last: Miller

4. DATE OF DEATH: Month: August — Day: 19 — Year: 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/20/89
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Schlosser
14. MOTHER'S MAIDEN NAME: Georgiana Avery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Norman Harry Miller — Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 9 weeks
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Arteriosclerosis — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 20, 1961, to August 19, 1961, that I last saw the deceased alive on Aug 19, 1961, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. Curry M.D. — ADDRESS (Street, city or town, state): 10620 Georgia Ave — DATE SIGNED: 8/19/61
PHYSICIAN'S NAME (Type): John J. Avery — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 8/23/61
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR: DATE AUG 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9353 — 09344

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2yrs. 6mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8500 Flower Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Janet — Middle: None — Last: Miller
4. DATE OF DEATH: Month: August — Day: 10 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-28-75
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Miller
14. MOTHER'S MAIDEN NAME: Sarah Colvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Washington San't Hosp. Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b) Auricular Fibrillation — years

DUE TO (c) Subacute Nephritis — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

433.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1956, 19, to Aug 10, 1961, that (I) (we) last saw the deceased alive on Aug 9 1961, and that death occured at 2:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert A. Hare M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 10, 61
22c. PHYSICIAN'S NAME (Type): Robert A. Hare MD.
22d. ADDRESS: 7600 Carroll Ave., T.P. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: Aug 11-61
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cem.
23d. LOCATION (City, town or county) (State): Hadenburgh Road Prince Geo, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: 254 Carroll St NW D.C.
25a. REC'D BY REGISTRAR: DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9354 **CERTIFICATE OF DEATH** 09345

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6105 Gloster Rd

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wash. 16, DC - Bethesda Md
d. STREET ADDRESS: 6105 Gloster Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BERNARD Middle: J Last: MONTY
4. DATE OF DEATH: Month: Aug Day: 12 Year: 1961
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 29 Feb 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months 6 Days 12 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weaver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Louis Monty
14. MOTHER'S MAIDEN NAME: Josephine ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 029-01-2222
17. INFORMANT: Mr Robert J Monty Address: 6105 Gloster Rd Bethesda Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) acute myocardial infarction — 1 hour.
527.1
DUE TO (b) Myocarditis, chronic — 1 year.
DUE TO (c) Emphysema, genl, severe — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 1960 to Aug 1961, that (I) (we) last saw the deceased alive on 4 Aug 1961, and that death occured at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Herbert Martyn Jr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12 Aug 61
22c. PHYSICIAN'S NAME (Type): HERBERT MARTYN JR
22d. ADDRESS: 5629 Bethesda Ave Beth md

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 8/16/61
23c. NAME OF CEMETERY OR CREMATORY: Bethany Cem.
23d. LOCATION (City, town or county) (State): Monson, Mass.

24 FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home, W23h DC ADDRESS 5107 Wis Ave
25a. REC'D BY REGISTRAR AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Case 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Dr Bernhard Mind Mitchell

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9355 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09346

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 13 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10115 Tenbrook Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

M

3. NAME OF DECEASED (Type or print): First: Jerome — Middle: NMN — Last: Morris

4. DATE OF DEATH: Month: 8 — Day: 24 — Year: 1961

I

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 7-31-08
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Y
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Max Morris
14. MOTHER'S MAIDEN NAME: Nettie Neuman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Old Hosp. Record.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMBOLISM, MASSIVE. — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
465X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
Address (Street, city, town, or county):
DATE SIGNED: 8-24-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG. 25, 1961
22c. NAME OF CEMETERY OR CREMATORY: CEDAR PARK CEMETERY
22d. LOCATION (City, town, or country): EMERSON — (State): N. J.

23. FUNERAL DIRECTOR: B Dougherty & Son — ADDRESS: 3501-14 St. N.W.
24a. REC'D BY REGISTRAR — DATE: AUG 28 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9356 09347

M 099 I

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Rockville
d. STREET ADDRESS: 4507 Muncaster Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Richard Last: Mulligan
4. DATE OF DEATH: Month: August Day: 22 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 1, 1927
9. AGE (In years last birthday): 33 yrs. IF UNDER 1 YEAR: Months 11 Days 21 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glazier
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Harry E. Mulligan
14. MOTHER'S MAIDEN NAME: Nora Earp
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days.
DUE TO
(b) Chronic coronary atherosclerosis — 4 yrs.
DUE TO
(c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 13, 1957, to Aug 22, 1961, that (I) (we) last saw the deceased alive on Aug 1 1961, and that death occurred at 7:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-23-61
22c. PHYSICIAN'S NAME (Type): Richard A. Yates, MD
22d. ADDRESS: Old Baltimore Road, Olney, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/25/61
23c. NAME OF CEMETERY OR CREMATORY: Neelsville Church Cem.
23d. LOCATION (City, town, or county) (State): Neelsville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9357 **CERTIFICATE OF DEATH** 09348

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3402 13th Place, S.E. Apt 101
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Baby Middle: Boy Last: NAULT
4. DATE OF DEATH: Month: August Day: 27 Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-24-61
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: 3 IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Bethesda, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Arthur Nault
14. MOTHER'S MAIDEN NAME: Margaret Ann Howard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George A. Nault Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Disease, congenital, cyanotic — INTERVAL BETWEEN ONSET AND DEATH: 3 days
754.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 24, 1961 to August 27, 1961, that (I) (we) last saw the deceased alive on 27 August 1961, and that death occured at 3:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Lawrence G. Thorne M.D.
22b. DATE SIGNED: August 28, 1961
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Lawrence G. Thorne, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 30 August 1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City, town or county): Washington (State): D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Lemmon Brochen
ADDRESS: Washington, D.C.
Simmons Brother, 1661 Good Hope Rd. S.E.
25a. REC'D BY REGISTRAR DATE AUG 30 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9358 **CERTIFICATE OF DEATH** (9349)

1 M 050 I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 28 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Apalachin
d. STREET ADDRESS: 19 Meadow Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

69X-1

3. NAME OF DECEASED (Type or print): First: NANCY Middle: MARIE Last: NINNIE
4. DATE OF DEATH: Month: August Day: 9, Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 8, 1960
9. AGE (In years last birthday): 1 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Child)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Eugene R. Ninnie
14. MOTHER'S MAIDEN NAME: Elizabeth Lang
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tetralogy of Fallot — INTERVAL BETWEEN ONSET AND DEATH: Congenital

754.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 12, 19 61 to August 9, 19 61 that (I) (we) last saw the deceased alive on August 9, 19 61, and that death occured at 1:47 PM from the causes and on the date stated above.

22a. SIGNATURE: Richard P. Anderson M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-10-61
22c. PHYSICIAN'S NAME (Type): RICHARD P. ANDERSON, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Tran.
23b. DATE THEREOF: 8/10/61
23c. NAME OF CEMETERY OR CREMATORY: St. Joachims Cemetery
23d. LOCATION (City, town or county) (State): Beacon, New York

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/60

Montgomery New York

Bethesda 28 days Apalachin

The Clinical Center 17 Meadow Lane

NAMCY MALE NUMBER August 9, 61

Female White August 6, 1960 I

None (Child) None New York USA

Eugene H. Nunnie Elizabeth Lane

No The Medical Record

None The Clinical Center, Bethesda 14, Maryland

Pathology of Pallet

July 12, 61 August 9, 61

August 9, 61

1:47 pm

B-10-61

RICHARD P. ANDERSON, M.D. The Clinical Center, National Institutes of Health, Bethesda 14, Md.

Burial-Tran. 6/10/61 St. Joachims Cemetery Beacon, New York

Robert A. Pumphrey, Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9359 **CERTIFICATE OF DEATH** 09350

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Sant Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New York
b. COUNTY: 67X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hollis 23
d. STREET ADDRESS: 197-13 89th Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Marie; Middle: NMN; Last: Nisius
4. DATE OF DEATH: Month: 8; Day: 6; Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 4-1-88
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): HSWF
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FRED HESS
14. MOTHER'S MAIDEN NAME: ELIZABETH WELZ
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. Emma M. Montay — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Occlusion + Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b) Coronary Sclerosis — several years
DUE TO (c) Generalized Arteriosclerosis — several years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CORONOR NOTIFIED AND APPROVED

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7:45 PM Aug 6, 1961 to 8:45 PM Aug 6 1961, that (I) (we) last saw the deceased alive on Aug 6 1961, and that death occured at 8:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Marvin L. Kolkin M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): MARVIN L. KOLKIN
22d. ADDRESS: 1015 Spring Street, S.S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/10/61
23c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEMETERY
23d. LOCATION (City, town or county) (State): MIDDLE VILLAGE LONG ISLAND, N.Y.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska ADDRESS: Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Ave, Silver Spring
25a. REC'D BY REGISTRAR: AUG 9 '61 DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09351

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5620 Woodway Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5620 Woodway Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lois — Middle: Nelson — Last: Noble

4. DATE OF DEATH: Month: 8 — Day: 14 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/2/13

9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington State

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jay W. Nelson

14. MOTHER'S MAIDEN NAME: Lena McIntire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Husband — Address: W. R. Noble.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fat embolism
581.1
DUE TO
(b) hepatic fatty metamorphosis
DUE TO
(c) Cronic alcoholism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8-15-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/16/61

22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

22d. LOCATION (City, town, or country) (State): Rockville, Maryland

23. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland — ADDRESS

24a. REC'D BY REGISTRAR — DATE: AUG 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9361 (9352)

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery 14
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2400 Colesville-Beltsville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

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3. NAME OF DECEASED (Type or print): First: Evan — Middle: Carter — Last: Noonan

4. DATE OF DEATH: Month: AUG. — Day: 23, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-12

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist

10b. KIND OF BUSINESS OR INDUSTRY: N.O.L. U.S. GOVT.

11. BIRTHPLACE (County & State, or foreign country): Vermont

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: William Noonan

14. MOTHER'S MAIDEN NAME: Fannie Sears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give were or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hosp. Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) — coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 14 h.
420.1
DUE TO (b) — coronary arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-2 wd, 19 61 to 8-23, 19 61 that (I) (we) last saw the deceased alive on 8-23 19 61, and that death occured at 7:25 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Veronika Troost M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): VERONIKA TROOST

22d. ADDRESS: 10236 N. Hol. Ave. Silver Spring Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 28-1961

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial

23d. LOCATION (City, town or county): Charleston — (State): West Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Arthur Stokes — ADDRESS: 254 Carroll St NW DC

25a. REC'D BY REGISTRAR DATE AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09353

1. PLACE OF DEATH 9362
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 46 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chincoteague
d. STREET ADDRESS: Ridge Road 83X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrtle; Middle: Virginia; Last: Novak

4. DATE OF DEATH: Month: August; Day: 11; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-27-17

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Earl Birch

14. MOTHER'S MAIDEN NAME: Elsie Bowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Frank J. Novak — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO (b) Carcinoma of the ovary.
DUE TO (c)

175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from June 26, 1961 to August 11, 1961 that I (we) last saw the deceased alive on August 11 1961, and that death occured at 5:00 PM from the causes and on the date stated above.

22a. SIGNATURE: Arthur O. Anctil Jr. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 12, 1961

22c. PHYSICIAN'S NAME (Type): Arthur O. Anctil, Jr. LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 16, 1961

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town or county) (State): Chincoteague Va

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Raymond G. Pumphrey for Salyer Funeral Home, Chincoteague, Va.

25a. REC'D BY REGISTRAR DATE: AUG 16 61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9363 — 09354

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Great Falls 83X-3
d. STREET ADDRESS: RFD # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willard — Middle: Moore — Last: Oliver

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-21-97

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Electrical

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin Oliver

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.:

17. INFORMANT: (S) Charles Oliver — Address: 4215 S. Four Mile Dr. Arlington Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): metastasis
DUE TO (c): Bronchogenic Carcinoma

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from July 27, 1961, to August 21 19 61 that I (we) last saw the deceased alive on August 21 19 61, and that death occured at 9:30 PM from the causes and on the date stated above.

22a. SIGNATURE: D. L. Kettering M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 22 August 1961
22c. PHYSICIAN'S NAME (Type): D. L. KETTERING, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 25 August 1961
23c. NAME OF CEMETERY OR CREMATORY: Arnon Cemetery
23d. LOCATION (City, town or county) (State): Great Falls Va.

24. FUNERAL DIRECTOR'S SIGNATURE: CC Pearson
ADDRESS: Pearson's. 472 N. Washington, Falls Church, Va.

25e. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9364 **CERTIFICATE OF DEATH** 09355

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5517 Hoover Street

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5517 Hoover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James; Middle: E.; Last: O'Neill

4. DATE OF DEATH: Month: August; Day: 4; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-15-1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd Mail Room

10b. KIND OF BUSINESS OR INDUSTRY: Trinity College

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward J. O'Neill

14. MOTHER'S MAIDEN NAME: Bridget Galvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)

16. SOCIAL SECURITY NO.: 579-10-5946

17. INFORMANT: Mary M. Usilton — Address: 5517 Hoover St. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hr
420.0
DUE TO (b): Arterio-sclerotic heart — ?
DUE TO (c): Generalized arterio-sclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paralysis of the muscles used in swallowing

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb. 1, 1961, to Aug. 4, 1961, that (I) (~~was~~) last saw the deceased alive on Aug. 2, 1961, and that death occured at 2 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Walter K. Angevine, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 4, 1961

22c. PHYSICIAN'S NAME (Type): WALTER K. ANGEVINE, M.D.

22d. ADDRESS: 6300 - 13th ST., N.W., WASH., D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-7-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins — ADDRESS: 3821-14th St. N.W. Wash. DC

25a. REC'D BY REGISTRAR DATE AUG 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9365 09356

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): B & O R R tracks.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 08 Gaithersburg
d. STREET ADDRESS: Stewardtown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Euell; Middle: Owens; Last:
4. DATE OF DEATH: Month: 8/26/61; Day: ; Year: 19

5. SEX: male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/17/85
9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Owens
14. MOTHER'S MAIDEN NAME: Augusta Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Police record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries, extreme — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b) Head partially decapated
DUE TO (c)

812X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by passenger train while walking on RR tract
20c. TIME OF INJURY: Hour e.m. 11:25 ~~p.m.~~ Month, Day, Year: 8/26/61
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): B & O R R
20f. (City or town): Gaithersburg (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county):
DATE SIGNED: 8/27/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or country): Arlington, Va (State):

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville Md.
24a. REC'D BY REGISTRAR: DATE SEP 1 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9366 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09357

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown - R-2
c. LENGTH OF STAY IN 1b: 2 1/2 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Black Rock Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Bethesda
d. STREET ADDRESS: 10508 Montrose Ave - Apt No 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norvell — Middle: Wordsworth — Last: Page
4. DATE OF DEATH: Month: Aug — Day: 14 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-12-1904
9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired): Information Specialist
10b. KIND OF BUSINESS OR INDUSTRY: A.E.C. Industrial News Br.
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Charles W. Page 226-20-7068
14. MOTHER'S MAIDEN NAME: Estlie Bethel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: 226-20-7068
17. INFORMANT: Jean Page (wife) — Address: Ellicott City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

42001

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
Address (Street, city, town, or county):
DATE SIGNED: 8-14-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/18/61
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or country) (State): Rockville, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE AUG 21 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Hawes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9367

CERTIFICATE OF DEATH

09358

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oakhaven Convalescent Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hopewell
d. STREET ADDRESS: 67 X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Annie Middle: French Last: Palmer

4. DATE OF DEATH: Month: Aug Day: 24 Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 13 1876

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harvey Roop.

14. MOTHER'S MAIDEN NAME: Agnes Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mrs. Edith Popenoe, 9502 Thorn Hill Rd., Address Silver Sp., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO (b) Generalized arteriosclerosis — Several years
DUE TO (c)

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 7 1961, to August 24, 1961, that (I) (we) last saw the deceased alive on August 18 1961, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 24, 1961

22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr. M.D.

22d. ADDRESS: 9301 Colesville Rd., Silver Spring Md.

23a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~

23b. DATE THEREOF: 8/25/61

23c. NAME OF CEMETERY OR CREMATORY: Highlands Cemetery

23d. LOCATION (City, town, or county) (State): Hopewell, N.J.

24. FUNERAL DIRECTOR'S SIGNATURE: S. H. Hines Co. ADDRESS: 2901-14th St. NW. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and transmitted within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9368 **CERTIFICATE OF DEATH** 09359

Items 23 Film 6292 8/10/61 lwk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 Bethesda
d. STREET ADDRESS: 1 9209 Bulls Run Pkwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thad — Middle: — Last: Patrick
4. DATE OF DEATH: Month: August — Day: 3 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-21-25
9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USPHS
10b. KIND OF BUSINESS OR INDUSTRY: Sanitary Engineer
11. BIRTHPLACE (County & State, or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William T. Patrick
14. MOTHER'S MAIDEN NAME: Lula Bond
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Carolyn M. Patrick Same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 17 DAYS

330X

DUE TO (b) RUPTURED INTRACRANIAL ANEURYSM — 17 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from July 17, 1961 to August 3, 1961, that ~~I~~ (we) last saw the deceased alive on August 3, 1961, and that death occured at 9:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: R.W. MacKie M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: August 4, 1961
22c. PHYSICIAN'S NAME (Type): R.W. MACKIE CAPT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/8/61
23c. NAME OF CEMETERY OR CREMATORY: Capitol Mem. Gardens
23d. LOCATION (City, town or county) (State): Austin, Texas

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
Robert A. Pumphrey, 7557 Wisconsin Ave.
25a. REC'D BY REGISTRAR — DATE: AUG 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9369

CERTIFICATE OF DEATH

09360

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park, Md.
d. STREET ADDRESS: 1820 2 Flower Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JULIUS Middle: CARL Last: PETER
4. DATE OF DEATH: Month: Aug Day: 5 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 5 1894
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reviser & Reader
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Chicago Illinois
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julius C. Peter Sr
14. MOTHER'S MAIDEN NAME: Lena Kramer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Phlebitis L leg
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ——— 19..., to ——— 19..., that (I) (we) last saw the deceased alive on 8/5 1961, and that death occured at 9:50A M, from the causes and on the date stated above.

22a. SIGNATURE: Chas H Wolohon M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Chas H WOLOHON
22d. ADDRESS: 7600 Carroll Ave TP

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug-10-61
23c. NAME OF CEMETERY OR CREMATORY: Rock Hill
23d. LOCATION (City, town or county) (State): Berrien Springs Michigan

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters
ADDRESS: 254 Carroll St NW
25a. REC'D BY REGISTRAR DATE: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9370 — 09361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

1 M I

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 818 GIST AVENUE

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 818 GIST AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA — Middle MACLEOD — Last PLUNKETT

4. DATE OF DEATH: Month AUGUST — Day 29, — Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: NOVEMBER 2, 1890

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER-RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY MACLEOD

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.:

17. INFORMANT: MR. CHARLES T. PLUNKETT — Address: 818 GIST AVENUE SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE INTESTINAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 18 HRS.
578X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1948 to 29 AUG., 1961, that (I) (we) last saw the deceased alive on 29 AUG. 1961, and that death occured at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. B. Snow M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/29/61

22c. PHYSICIAN'S NAME (Type): LEE B. SNOW

22d. ADDRESS: 7950 NEW HAMPSHIRE AVENUE

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 9/1/61

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEMETERY

23d. LOCATION (City, town or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Ziska — ADDRESS: 8434 GEORGIA AVENUE

WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND

25a. RECD. BY REGISTRAR — DATE: AUG 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9371 **CERTIFICATE OF DEATH** 09362

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 07 GAITHERSBURG
d. STREET ADDRESS: 1 15 DESELLUM AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First THOMAS Middle HERBERT Last POPE
4. DATE OF DEATH: Month AUGUST Day 22 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 19, 1872
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED- GOVERNMENT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

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13. FATHER'S NAME: JOSEPH POPE
14. MOTHER'S MAIDEN NAME: MATILDA THOMPSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: HOSPITAL RECORDS Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emboli, Pulmonary — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Thrombophlebitis, femoral, right.
DUE TO (c)

464X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 10, 1961 to Aug. 22, 1961, that (I) (we) last saw the deceased alive on Aug. 21 1961, and that death occured at 9:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8.22.61
22c. PHYSICIAN'S NAME (Type): J. SCHUMACHER, M. D.
22d. ADDRESS: GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-24
23c. NAME OF CEMETERY OR CREMATORY: Wesley Grove Cemetery
23d. LOCATION (City, town or county) (State): Woodfield. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9372

CERTIFICATE OF DEATH

09363

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 31 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 3925 Chesterbrook Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle CLAY — Last PRYOR
4. DATE OF DEATH: Month August — Day 10, — Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 26, 1906
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Management Analyst
10b. KIND OF BUSINESS OR INDUSTRY: Army
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Pryor
14. MOTHER'S MAIDEN NAME: Carrie Winters
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure With Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b) Amyloidosis with Multiple Myeloma — 2 Months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

289.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 10, 1961 to August 10, 1961, that (I) (we) last saw the deceased alive on August 10, 1961, and that death occured at 10:55 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert H. Levin M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/10/61
22c. PHYSICIAN'S NAME (Type): Robert H. Levin M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 8/14/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Ft. Myer, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9373 **CERTIFICATE OF DEATH** 09364

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda,
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Herndon 83 x 3
d. STREET ADDRESS: Rt # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael; Middle: James; Last: Rentfrow

4. DATE OF DEATH: Month: August; Day: 31; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 18, 1961

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 1; Days: 13; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jess W. Rentfrow

14. MOTHER'S MAIDEN NAME: Darlene M. Caldwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: (M) Darlene M. Rentfrow Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital Heart Disease; Transposition of Great Vessels
754.0
DUE TO (b)
DUE TO (c)
Conditions, if any, which geva rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from August 26, 1961 to August 31, 1961 that ~~I~~ (we) last saw the deceased alive on August 31 1961, and that death occured at 1:10 AM, from the causes and on the date stated above.

22a. SIGNATURE: James E. McClenathan M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: August 31, 1961

22c. PHYSICIAN'S NAME (Type): JAMES E. McCLENATHAN, CDR MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2 Sept 1961

23c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove Cemetery

23d. LOCATION (City, town or county): Herndon (State): Va.

24 FUNERAL DIRECTOR'S SIGNATURE: J. E. Stephen ADDRESS: Green Funeral Home, Herndon, Va.

25a. REC'D BY REGISTRAR DATE SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Hause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9374 Items 8 & 9 Film C292 8/14/61 mb 09367

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Silver Spring
d. STREET ADDRESS: 1 Route I Norwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: WARREN; Middle: ; Last: Riggs
4. DATE OF DEATH: Month: August; Day: 1; Year: 1961
5. SEX: Male
6. COLOR OR RACE: C.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 26 1903
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS.: Hours ; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: Mont. C. Road Comm.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Riggs
14. MOTHER'S MAIDEN NAME: Mary Dorsey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): ARMY
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Charlotte Riggs (Same as above) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Herniation of Brain Stem — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Cerebral Edema — 1 Day
DUE TO (c) Cerebral Concussion — 1 Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
912.5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Caught between air compressor + truck while unloading comp.
20c. TIME OF INJURY: Hour 12:42 p.m.; Month, Day, Year: 7-31 1961
20d. INJURY OCCURRED: While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town): Wheaton (County): Montg. (State): Md
21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐
ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/6/61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant.
22d. LOCATION (City, town, or country): Norbeck, Md. (State):
23. FUNERAL DIRECTOR: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: DATE AUG 7 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please complete the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9375 **CERTIFICATE OF DEATH** 09368

Item 7 Film G292 8/15/61 jwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8017 Barron

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8017 Barron
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Edward Middle: A. Last: Roberts
4. DATE OF DEATH: Month: August Day: 4 Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 25, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Printing Business
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pittsburgh Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eugene Roberts
14. MOTHER'S MAIDEN NAME: Jennie Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Hazel L. Roberts Address: 8017 Barron St. Takoma Park

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia and Cachexia, Cancer
DUE TO (b): Cerebral Thrombosis
DUE TO (c): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: July 24

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jun, 1961, to Aug 4, 1961, that (I) (we) last saw the deceased alive on Aug 4, 1961, and that death occured at 10.15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Chas. H. Wolohan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Chas. H. Wolohan
22d. ADDRESS: 7600 Carroll Ave Takoma Park

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 7-1961
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town or county) (State): Hyattsville Md. Prince Geo. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 254 Carroll St NW WASH DC
25a. REC'D BY REGISTRAR DATE: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9376 Reg. Dist. No. 09369

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: X

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Poolesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle E. Last ROBINSON
4. DATE OF DEATH: Month AUGUST Day 3 Year 1961

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr. 27, 1884
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Robinson
14. MOTHER'S MAIDEN NAME: Jennie Hollings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Mary Jackson — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CACHEXSIA — INTERVAL BETWEEN ONSET AND DEATH: 6 months
1775X
DUE TO (b) METASTATIC CARCINOMA — 4 YEARS
DUE TO (c) CARCINOMA OF PROSTATE — 6 YEARS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to 3 Aug, 1961, that I last saw the deceased alive on 3 AUG., 1961, and that death occurred at 11 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Fawcett M.D. ADDRESS (Street, city or town, state): DAWSONVILLE DATE SIGNED: 3 AUG. 1961
PHYSICIAN'S NAME (Type): JOHN G. FAWCETT P.O. BOYD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/7/61
22c. NAME OF CEMETERY OR CREMATORY: Elijah Methodist
22d. LOCATION (City, town, or county) (State): Poolesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: AUG 11 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9377

CERTIFICATE OF DEATH

09370

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westmont
d. STREET ADDRESS: 120 French Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: May — Last: Robinson

4. DATE OF DEATH: Month: Aug — Day: 17 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-26-88
9. AGE (In years lost birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Teaching
11. BIRTHPLACE (State or foreign country): England.
12. CITIZEN OF WHAT COUNTRY? Amer.
13. FATHER'S NAME: Edwin Robinson
14. MOTHER'S MAIDEN NAME: Mary Morgan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Washington San + Hosp. Takoma Park Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 Months
434.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myxedema Arthritis - Osteo.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 8/9 1961 to 8/17 1961 that (I) (we) last saw the deceased alive on 8-17-1961, and that death occurred at 4:15 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Robert A. Hare M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/17/61
22c. PHYSICIAN'S NAME (Type): Robert A. Hare
22d. ADDRESS: 7600 Carroll Ave. T. Pk. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 21, 1961
23c. NAME OF CEMETERY OR CREMATORY: Locust Wood Cemetery
23d. LOCATION (City, town, or county) (State): Camden New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR: AUG 21 '61 DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Kyburz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9378 **CERTIFICATE OF DEATH** 09371

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 13402 Keating Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Lewis — Last: Ronk, Sr.

4. DATE OF DEATH: Month: August — Day: 13 — Year: 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 10 1906
9. AGE (In years last birthday): ~~55~~ 54
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Manager - Montgomery County
10b. KIND OF BUSINESS OR INDUSTRY: Liquor Dispensary
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: George Columbus
14. MOTHER'S MAIDEN NAME: Rosa Ledbetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 578-05-3463
17. INFORMANT: Hospital Record. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure
DUE TO (b): Myocardial infarction
DUE TO (c): Coronary insufficiency

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3hrs 40min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 am 13 Aug., 1961, to 4½ am 13 Aug, 1961, that (I) (we) last saw the deceased alive on 13 Aug 1961, and that death occured at 3½ A.M, from the causes and on the date stated above.

22a. SIGNATURE: Chester Wong M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 13 Aug 1961
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 7722 Maple Ave, Takoma Park 12, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Montgomery County, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue
25a. REC'D BY REGISTRAR DATE: AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Hanna

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9379

CERTIFICATE OF DEATH

09372

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 1 day

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Boyds

d. STREET ADDRESS: R.R.S.

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

074

3. NAME OF DECEASED (Type or print): First: Lennie Middle: R. Last: Rose

4. DATE OF DEATH Month: Aug. Day: 3 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/5/07

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah Farmer

14. MOTHER'S MAIDEN NAME: Annie Smallwood.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Claude Rose Address: Same As Above.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic PANCREATITIS — INTERVAL BETWEEN ONSET AND DEATH: 2d

587.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/2, 1961, to 8/3, 1961, that (I) (we) last saw the deceased alive on 8/3 1961, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Brewer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ROBERT G. BREWER

22d. ADDRESS: 8218 WISCONSIN AVE BETH

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/7/61

23c. NAME OF CEMETERY OR CREMATORY: Yellow Hill

23d. LOCATION (City, town, or county) (State): Pike County, Kentucky

24. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molsworth ADDRESS: Damascus, Md.

25a. REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Clifford S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9380 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09373

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Bradley Blvd + Durbin Rd.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Va.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 837-3
d. STREET ADDRESS: ~~200~~ 142 Ivery Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hiram — Middle: Edward — Last: Rosenbaum
4. DATE OF DEATH: Month: Aug — Day: 2 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Whit
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-2-1911
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): electrician
10b. KIND OF BUSINESS OR INDUSTRY: Worked for contractors.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Ruby Rosenbaum-Wife-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/7/61
22c. NAME OF CEMETERY OR CREMATORY: Happy Valley Mem. Park
22d. LOCATION (City, town, or country) (State): Elizabethton, Tennessee
23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE AUG 7 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

IO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
IO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9381

CERTIFICATE OF DEATH

Reg. Dist. No. 09374

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9855 SINGLETON RD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 BETHESDA
d. STREET ADDRESS: 9855 SINGLETON RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ISRAEL — Middle: A — Last: ROSENBLUM

4. DATE OF DEATH: Month: AUGUST — Day: 5 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: NOV. 2, 1911

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER-STORE

10b. KIND OF BUSINESS OR INDUSTRY: DRY CLEANING

11. BIRTHPLACE (State or foreign country): WASH DC

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: MAX ROSENBLUM

14. MOTHER'S MAIDEN NAME: BLUME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MORRIS ACKERMAN — Address: 7307 ASHBORDA, CHC.H.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
420.1
DUE TO
(b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 8 YEARS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUGUST, 1953, to AUGUST, 1961, that I last saw the deceased alive on AUGUST 3, 1961, and that death occurred at 6 05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert L. Krichmar M.D. — ADDRESS (Street, city or town, state): 7733 ALASKA AVENUE NW — DATE SIGNED: AUGUST 5 1961

PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR — WASHINGTON 12 D.C.

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 6, 1961

22c. NAME OF CEMETERY OR CREMATORY: KING DAVID MEMORIAL GARDEN

22d. LOCATION (City, town, or county) (State): FALLS CHURCH Va.

23. FUNERAL DIRECTOR'S SIGNATURE: B Dwyer and Sons — ADDRESS: 3501-14 ST NW

24a. REC'D BY REGISTRAR DATE: AUG 9 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1M-9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9382 — 09375

1 (M)

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harlan
d. STREET ADDRESS: Browning, Apt. #17, Harlan Memorial Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

55X-3

050

3. NAME OF DECEASED (Type or print): First: Sergio — Middle: Bastos — Last: Santos
4. DATE OF DEATH: Month: August — Day: 19, — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 18, 1960
9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ottao A. Santos
14. MOTHER'S MAIDEN NAME: Suzanna B. Fausto
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda, 14, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic passive congestion of liver — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
754.0
DUE TO (b) Congestive heart failure with pulmonary edema and — 6 weeks
DUE TO (c) Tetralogy of Fallot — Congenital

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Postoperative Blalock anastomosis of right subclavian artery to right pulmonary artery

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 14, 19 61 to August 19, 19 61 that (I) (we) last saw the deceased alive on August 19, 19 61, and that death occured at 11:00AM from the causes and on the date stated above.

22a. SIGNATURE: T Merigan Jr M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/19/61
22c. PHYSICIAN'S NAME (Type): THOMAS MERIGAN, JR., M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 23, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City, town or county) (State): Harlan, Kentucky
24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey — ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE AUG 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S Hand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9383

CERTIFICATE OF DEATH

09376

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 708-Philadelphia Ave. Shannon Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery (Prince Geo.)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 1653-2
d. STREET ADDRESS: 952-East-West Hwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Angelo; Middle: J.; Last: Scandolos
4. DATE OF DEATH: Month: Aug.; Day: 11; Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 25-1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Resturant Owner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Scandolos
14. MOTHER'S MAIDEN NAME: Helen Margelos

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Nursing Home Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Months
DUE TO
(b) Hypertensive Heart Disease
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1958 to Aug 1961, that (I) (we) last saw the deceased alive on Aug 10 1961, and that death occurred at 2:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Dwayne Chickfield M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/11/61
22c. PHYSICIAN'S NAME (Type): DWAYNE CHICKFIELD
22d. ADDRESS: 6826 Eggs Pl Hyatts Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 8/14/61
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9384 **CERTIFICATE OF DEATH** 09377

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 29 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 716 Forston Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALVIN; Middle: VERNON; Last: SCHEIBLE

4. DATE OF DEATH: Month: August; Day: 3; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 4, 1928
9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Charles Scheible
14. MOTHER'S MAIDEN NAME: Eldora King
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

204.3

DUE TO (b) Acute lymphocytic leukemia — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mongolism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from July 5, 1961, to August 3, 1961 that (I) (we) last saw the deceased alive on August 3, 1961, and that death occured at 7:00AM from the causes and on the date stated above.

22a. SIGNATURE: Geo. H. Porter III M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/3/61
22c. PHYSICIAN'S NAME (Type): GEORGE H. PORTER, III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 7-1961
23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill
23d. LOCATION (City, town or county): Washington + N. Ste (State): D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur Gallery
ADDRESS: 2514 Carroll St N.W.
25a. REC'D BY REGISTRAR DATE: AUG 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kirwan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Geo. H. Porter III

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9385 **CERTIFICATE OF DEATH** 09378

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Bella Vista Nursing Home 571 University Blvd, East ~~Sixx~~

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: DC
b. COUNTY: --
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3724 New Hampshire Ave. NW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alice, Middle L., Last Shadle
4. DATE OF DEATH: Month August, Day 11, Year 1961
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/21/1872
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Ava, New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unobtainable
14. MOTHER'S MAIDEN NAME: Unobtainable
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Records at Nursing Home -- See #1 — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis & Congestive heart failure — 24 hrs
DUE TO (b) Generalized arteriosclerosis — 8 yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 15, 1957 to Aug 11, 1961, that (I) (we) last saw the deceased alive on 8-11 1961, and that death occured at 9:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Chas W Harnsberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-11-61
22c. PHYSICIAN'S NAME (Type): CHAS. W. HARNSBERGER
22d. ADDRESS: 4201 NEW HAMP. AVE N.W.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE AUG 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9386 ~~Item 22b, Film G292 8/15/61 lvk~~ 09379

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 x 3
d. STREET ADDRESS: 4701 Connecticut Ave.N.W.Apt 401
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: McDermott — Last: Shirley
4. DATE OF DEATH: Month: August — Day: 7 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12 March 1936
9. AGE (In years last birthday): 25 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: M. J. McDermott
14. MOTHER'S MAIDEN NAME: Rose Fuller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Arthur Shirley — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage (spontaneous)
DUE TO (b) 2° to ruptured berry aneurysm.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

330 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ Joseph J. Burke, Jr. LT(MC)USN

ACTUAL SIGNATURE: Frank J. Brochart M.D.
EXAMINER'S NAME (Type): Frank J. Brochart, M. D.
Address (Street, city, town, or county):
DATE SIGNED: August 7, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 10, 1961
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country) (State): Arlington Va.

23. FUNERAL DIRECTOR: Timothy Hanlon Funeral Home — ADDRESS: 4746 Wisconsin Ave Washington, D. C.
24a. REC'D BY REGISTRAR: DATE AUG 10 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Timothy Hanlon Fun. Hm. Wmc Friesen

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9387

CERTIFICATE OF DEATH

Reg. Dist. No. 09380

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2309 Seibel Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Silver Spring

d. STREET ADDRESS: 2309 Seibel Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadie Middle: Agnes Last: Smith

4. DATE OF DEATH Month: August Day: 13th Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: April 6th 1890

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Prince Geo. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard A Windsor,

14. MOTHER'S MAIDEN NAME: Rose H. Hutchin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Earl L. Smith Address: 2309 Seibel Dr. S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO (b) Generalized arteriosclerosis — 12 yrs.

DUE TO (c) Endometriosis — 10 yrs.

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 22, 1942 to August 13 1961, that I last saw the deceased alive on 8-13-61, 1961, and that death accurred at 9:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Kenneth Haughlin M.D. ADDRESS (Street, city or town, state): 934 Ellsworth Dr. Silver Spring Md DATE SIGNED: 8-13-61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/15/61

22c. NAME OF CEMETERY OR CREMATORY: Epiphany Cemetery

22d. LOCATION (City, town, or county) (State): Forestville Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 5801 Cleveland Ave Riverdale Md

24a. FILED BY REGISTRAR DATE: AUG 16 61

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

Item 18 Film 293 8-18-61 ams

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9388 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09381

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 10 Minutes.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 1301 15th. St. N.W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

47 X -3

074

3. NAME OF DECEASED (Type or print): First LYNN Middle L. Last SOUTTER

4. DATE OF DEATH: Month AUG. Day 9 Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: July 28 1908

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Advertising Business

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): D.C

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: EDGAR SOUTTER

14. MOTHER'S MAIDEN NAME: LILLIE LYNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 057-10-9284

17. INFORMANT: Mrs. Paul Snaver — Address: 9506 Mill Stead Dr. Bethesda Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of Gastric contents — INTERVAL BETWEEN ONSET AND DEATH: Sudden

154X

DUE TO
(b) Intestinal obstruction — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(c) Carcinoma of rectum — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brochart M.D.

EXAMINER'S NAME (Type): Frank J. Brochart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 8-9-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 8-9-61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Dumfries Cemetery

22d. LOCATION (City, town, or country) (State): Dumfries, Virginia

23. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE AUG 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9389 **CERTIFICATE OF DEATH** 09382

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dayton
d. STREET ADDRESS: 1314 Harvard Boulevard
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

72X-3

3. NAME OF DECEASED (Type or print): First WILLIAM Middle WAITT Last SPURGEON
4. DATE OF DEATH: Month August Day 4, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 17, 1898
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Circulation Manager
10b. KIND OF BUSINESS OR INDUSTRY: Newspaper
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John S. Spurgeon
14. MOTHER'S MAIDEN NAME: Carrie Waitt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record Address: National Institutes of Health, Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 8 months

162.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 11, 1961 to August 4, 1961 that (I) (we) last saw the deceased alive on August 4, 1961, and that death occured at 1:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: Robert H. Levin M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/4/61
22c. PHYSICIAN'S NAME (Type): ROBERT H. LEVIN, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
23b. DATE THEREOF: 8/6/1961
23c. NAME OF CEMETERY OR CREMATORY: College Park Cemetery
23d. LOCATION (City, town or county) (State): East Point, Georgia

24. FUNERAL DIRECTOR'S SIGNATURE: Jos. Lawton Sons Jr. ADDRESS: 1756 Pa. Ave.
25a. REC'D BY REGISTRAR DATE: AUG 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9390 **CERTIFICATE OF DEATH** 09383

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Restmor Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Dist. of Col. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington DC
d. STREET ADDRESS: 1410 M. St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: L — Last: Stephens
4. DATE OF DEATH: Month: Aug — Day: 27 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 7 1876
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Secy US govt.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wilbur Stephens
14. MOTHER'S MAIDEN NAME: Leaverton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No non — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Winifred M Hager — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 da
DUE TO (b): Cardio vascular disease — 4 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 49, 19.. to Aug 27 61, 19.., that (I) (we) last saw the deceased alive on Aug 27 1961, and that death occured at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E.E. Quayle M.D.
22b. DATE SIGNED: 8-27-61
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): E.E. Quayle M.D.
22d. ADDRESS: 1822 Biltmore St N.W. Washington D.C.

23a. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify)
23b. DATE THEREOF: 8-28-61
23c. NAME OF ~~CEMETERY~~ OR CREMATORY: Lee's
23d. LOCATION (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: Washington DC
25a. REC'D BY REGISTRAR DATE: AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9391

CERTIFICATE OF DEATH

Reg. Dist. No. 09384

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9006 LINTON ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 19006 LINTON ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LINA Middle Last STERN
4. DATE OF DEATH: Month AUG. Day 20 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 29, 1888
9. AGE (In years last birthday): 72 Yrs. IF UNDER 1 YEAR: Months, Days, Hours, Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BABY SITTER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: ABRAHAM GOLDSCHMIDT
14. MOTHER'S MAIDEN NAME: BETTY KLEEBLATT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 088-20-1868
INFORMANT: MRS LISELOTT FEFFERMAN Address: 9006 LINTON ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 10 to 15 minutes
420.1
DUE TO (b) Coronary artery arteriosclerosis — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of right ovary with metastasis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19____, to August 20, 1961, that I last saw the deceased alive on August 13, 1961, and that death occurred at 10:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Aaron H. Traum M.D. — ADDRESS (Street, city or town, state): 8237 Georgia Ave. — DATE SIGNED: Aug 20 61
PHYSICIAN'S NAME (Type): AARON H. TRAUM, M.D. — S.S. Spg. Md.

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~: BURIAL
22b. DATE THEREOF: AUG. 21, 1961
22c. NAME OF CEMETERY ~~OR CREMATORY~~: GEORGE WASHINGTON CEMETERY
22d. LOCATION (City, town, or county) (State): HYATTSVILLE Md.
23. FUNERAL DIRECTOR'S SIGNATURE: B Dreyfuss & Sons — ADDRESS: 3501-14 St NW
24a. REC'D BY REGISTRAR: DATE AUG 24 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9392

CERTIFICATE OF DEATH

11385

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5300 Westbard Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5300 Westbard Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle J. — Last STERZER

4. DATE OF DEATH: Month August — Day 1, — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 27, 1890
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months 11, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Wholesaler
10b. KIND OF BUSINESS OR INDUSTRY: Gas Station
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John N. Sterzer
14. MOTHER'S MAIDEN NAME: Alma Rupel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elsie W. Sterzer-Wife-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 YRS.
420.0
DUE TO (b): ~~Bronchopneumonia~~ corrected HES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ~~Chronic Pulmonary Emphysema~~

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia Chronic Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 29, 1961, to August 1, 1961, that (I) (we) last saw the deceased alive on July 29, 1961, and that death occured at 2:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Henry C. Scruggs M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): HENRY C. SCRUGGS
22d. ADDRESS: 7720 Wisconsin Ave. Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/4/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: AUG 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9393

CERTIFICATE OF DEATH

09386

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8001 Barron ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 8001 Barron Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MORRIS Middle L Last STIER.
4. DATE OF DEATH: Month August Day 25 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1874
9. AGE (In years lost birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John N. Stier
14. MOTHER'S MAIDEN NAME: Alvina Shipley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr Howard Stier — Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
420.0
DUE TO (b) arteriosclerotic heart disease — many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 1958 to Aug 24 1961, that (I) (we) last saw the deceased alive on Aug 24 1961, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James R Coleman M.D. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/25/61
22c. PHYSICIAN'S NAME (Type): JAMES R. COLEMAN
22d. ADDRESS: 7335 Sligo Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-28-61
23c. NAME OF CEMETERY OR CREMATORY: McKendree
23d. LOCATION (City, town, or county) (State): Cockeysville, Baltimore Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haught — ADDRESS: Lutherville, Md.
25a. REC'D BY REGISTRAR DATE: AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9394 **CERTIFICATE OF DEATH** 09387

Item 2 Film G293 8/29/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 174 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: U.S.Naval Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen; Middle: ; Last: Stissel

4. DATE OF DEATH: Month: August; Day: 20; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-22-25

9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Armed Forces

10b. KIND OF BUSINESS OR INDUSTRY: U. S.Navy

11. BIRTHPLACE (County & State, or foreign country): W. Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred D. Stissel

14. MOTHER'S MAIDEN NAME: Sadie Chafin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 8236-36-9095

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY METASTASES — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) RHABDOMYO SARCOMA LEFT THIGH
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 197.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): RADIATION PNEUMONITIS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from February 27, 1961 to August 20, 1961, that ~~I~~ (we) last saw the deceased alive on August 20 1961, and that death occured at 11:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: W. J. Mullins Jr. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 21 August 1961

22c. PHYSICIAN'S NAME (Type): W. J. MULLINS, JR. LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial - Shippment 22 Aug 1961

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Family Cemetery

23d. LOCATION (City, town or county): New Town (State): W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Wm Chambers per Robert E. Chambers
ADDRESS: W.W.Chambers, 1400 Chapin St. Washington, D.C.

25a. REC'D BY REGISTRAR DATE AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Nightingale

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9395

CERTIFICATE OF DEATH

Reg. Dist. No. 09388

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: five weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Montana
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre
d. STREET ADDRESS: 63X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lou; Middle: ; Last: Stringfellow
4. DATE OF DEATH: Month: August; Day: 3; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 13, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS.: Hours ; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Three Rivers, Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown Peek
14. MOTHER'S MAIDEN NAME: Almira Dimick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs. Virginia L. Bruner, Address: 1108 Highland Drive, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 5-10 yrs
DUE TO (b) Arteriosclerosis — ?
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Metastatic Carcinoma of lungs (Primary site unknown)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 58, to 3 Aug, 1961, that I last saw the deceased alive on 2 Aug, 1961, and that death occurred at 4:30 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: William D. Aud M.D. ADDRESS (Street, city or town, state): 906 Colesville Rd Silver Spring Md DATE SIGNED: 8/3/61
PHYSICIAN'S NAME (Type): WILLIAM D. AUD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial/Transit 8/7/61
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Glendale California
23. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Zisk ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue
24a. REC'D BY REGISTRAR DATE: AUG 7 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9395 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09389

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ~~Ft~~ Takoma Park
c. LENGTH OF STAY IN 1b: D.D.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San. + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10407 Berry Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Tyler Last: Stultz
4. DATE OF DEATH: Month: Aug Day: 3 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 8-11-11
9. AGE (In years last birthday): 50 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bar Tender. + Care Taker.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? USA.

I

13. FATHER'S NAME: William Stultz
14. MOTHER'S MAIDEN NAME: Cora ~~Watts~~ Ward.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 238-14-2466
17. INFORMANT: Mr. Tyler F Stultz. Address: 7602 Gridley La SS Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE — HOURS

DUE TO (b) CORONARY SCLEROSIS AND OCCLUSION, O.D. — MONTHS

DUE TO (c) ASPIRATION OF GASTRIC CONTENT — MINUTES.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIED IN AUTOMOBILE WHILE DRIVING

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 8-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 8/5/61
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Thursjay Church Cemetery
22d. LOCATION (City, town, or country) (State): Stokes County, Madison North Carolina

23. FUNERAL DIRECTOR: Raymond A. ZISKA. Warner E. Pumphrey, Inc.
ADDRESS: Silver Spring, Md. 8434 Georgia Avenue
24a. REC'D BY REGISTRAR: DATE AUG 9 '61
24b. REGISTRAR'S SIGNATURE: William S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9397 **CERTIFICATE OF DEATH** 09390

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9023 Flower Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucmma — Middle: Forest — Last: Tallman
4. DATE OF DEATH: Month 8 — Day 31 — Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-15-77
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Marshall G. Drake
14. MOTHER'S MAIDEN NAME: Elizabeth McQuain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause on line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis progressive — INTERVAL BETWEEN ONSET AND DEATH: 8/11/61
DUE TO (b): Diabetes Mellitus — 4/11/60
DUE TO (c): Chr. Deg. Myocardial + Hypertensive — 3 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/6/57, 19.., to 8/30/61, 19.., that (I) (we) last saw the deceased alive on 8/31/1961, and that death occured at 7:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Howard I. Snow M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried
23b. DATE THEREOF: Sept 4-61
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Ridge
23d. LOCATION (City, town or county) (State): Rockwood. Tenn.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Adkins — ADDRESS: 254 Carroll St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR: DATE SEP 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9398 **CERTIFICATE OF DEATH** 09391

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney, Md.
c. LENGTH OF STAY IN 1b: 6 days.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 425 N. Frederick Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leon — Middle: Albert — Last: Tarbox
4. DATE OF DEATH: Month: August — Day: 31 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-26-1899
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: AEC.
11. BIRTHPLACE (County & State, or foreign country): Warren, Penna.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Philip Sheridan Tarbox
14. MOTHER'S MAIDEN NAME: Grace Phillips.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CONGESTIVE HEART FAILURE	one year
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	OBSTRUCTIVE PULMONARY EMPHYSEMA	20 years
DUE TO (c)	ARTERIOSCLEROTIC HEART DISEASE	20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC RENAL INSUFFICIENCY - PEPTIC ULCER

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from FEB 1959 to SEPT 1, 1961, that (I) (we) last saw the deceased alive on August 31, 1961, and that death occured at 1205 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Gordon S Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: August 31, 1961
22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger
22d. ADDRESS: 310 W. Montg. Ave. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/2/61
23c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
23d. LOCATION (City, town or county) (State): Johnstown, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE SEP 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9399 **CERTIFICATE OF DEATH** 09392

1. PLACE OF DEATH
a. COUNTY: Montgomery, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md. 15
d. STREET ADDRESS: 12921 Columbia Pike 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mr. Alfred Middle Richard Last Taylor
4. DATE OF DEATH: Month 8 Day 10 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-30-1890
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months # Days 10 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Patent Examiner
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Patent Office
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Hannis Taylor
14. MOTHER'S MAIDEN NAME: Leonora Le Baron
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): None (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Record Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
570.5
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gastric Ulcers, Congestive Failure with Fibrillation
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1961, to Aug 10, 1961, that (I) (we) last saw the deceased alive on Aug 9 1961, and that death occured at 1:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert A. Hare, M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 10, 61
22c. PHYSICIAN'S NAME (Type): Robert A. Hare, M.D.
22d. ADDRESS: 7600 Carroll Ave. T.P. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11 AUG. 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): BLADENSBURG, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Rinaldi Funeral Home
ADDRESS: 816 H ST N.E. D.C.
25a. REC'D BY REGISTRAR DATE AUG 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

9400

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09393

1. PLACE OF DEATH
a. COUNTY: Suburban Hospital — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 42 days 1 hr.
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 06 Rockville
d. STREET ADDRESS: 1 Springridge Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: ; Last: Taylor
4. DATE OF DEATH: Month: August; Day: 20; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/8/01
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Wash., D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Boyd Taylor
14. MOTHER'S MAIDEN NAME: Marion Lilley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-18-1759
17. INFORMANT: Gladys Taylor, wife — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
DUE TO (b): Adeno Carcinoma of Rectum and Cecum — 3 months
DUE TO (c):
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1958, 19__, to July, 1961, that (I) (we) last saw the deceased alive on 20 August 19__, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: William S. Murphy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/20/61
22c. PHYSICIAN'S NAME (Type): William S. Murphy
22d. ADDRESS: 615 W. Mont. Ave., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/22/61
23c. NAME OF CEMETERY OR CREMATORY: Potomac Church Cem.
23d. LOCATION (City, town, or county) (State): Potomac, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Shaw

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9401

CERTIFICATE OF DEATH

09394

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Minnesota
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Saint Paul
d. STREET ADDRESS: 1758 Agate Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Rhys — Last: Thomsen

4. DATE OF DEATH: Month: August — Day: 6, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 6, 1934

9. AGE (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Producer-Director

10b. KIND OF BUSINESS OR INDUSTRY: Television

11. BIRTHPLACE (County & State, or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward J. Thomsen

14. MOTHER'S MAIDEN NAME: Mary Toy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give year or dates of service): 1956 - 1959

16. SOCIAL SECURITY NO.: 480-38-4494

17. INFORMANT: The Medical Record, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b) Anaplastic carcinoma, primary unknown, with bone marrow, hepatic, retroperitoneal & gastro-intestinal metastases — 7 months
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 6, 19 61 to August 6, 19 61, that (I) (we) last saw the deceased alive on August 6, 19 61, and that death occured at 9:15 PM from the causes and on the date stated above.

22a. SIGNATURE: Thorne S. Winter III M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8/7/61

22c. PHYSICIAN'S NAME (Type): THORNE S. WINTER, III, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

23b. DATE THEREOF: 8/8/61

23c. NAME OF CEMETERY OR CREMATORY: Masonic Cemetery

23d. LOCATION (City, town or county) (State): Iowa, Polk County, Des Moins

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9402 **CERTIFICATE OF DEATH** 09395

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~West Hyattsville~~ Adelphi 1657-2
d. STREET ADDRESS: ~~7500 Kuhlman Street~~ 1929 Laguna Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: White — Last: Van Horn
4. DATE OF DEATH: Month: August — Day: 5 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: July 25, 1891
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Security - Guard
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John A. Van Horn
14. MOTHER'S MAIDEN NAME: Annie E. Tucker

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO. (If yes give were or dates of service): 577-05-4056
17. INFORMANT — Address: Washington Sanitarium + Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma with metastases to bone + pathological fracture of right femur.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 1960 to Aug 5 1961 that (I) (we) last saw the deceased alive on Aug 5 1961, and that death occured at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Boris Rabkin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/6/61
22c. PHYSICIAN'S NAME (Type): BORIS RABKIN
22d. ADDRESS: 1019 University Blvd, East Silver Spring

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~
23b. DATE THEREOF: Aug. 9, 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. Raymond E. Pisda
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE AUG 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

Male White X

Married - Security - Guard

John A. Van Horn

No ---------- Washington Sanitarium & Hospital Reveille

1

9403

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09396

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
d. STREET ADDRESS: Carrs Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dwayne; Middle Carl; Last Viers
4. DATE OF DEATH: Month August; Day 27; Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/30/60
9. AGE (In years lost birthday): — yrs. IF UNDER 1 YEAR: Months 10; Days; IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Tivis C. Viers
14. MOTHER'S MAIDEN NAME: Agnes Rasnick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive Heart failure & pul. edema	4 hours
DUE TO (b)	Toxemia	24 hours
DUE TO (c)	Enteritis	8 days

571.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia, Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 8/24, 1961 to 8/27, 1961, that (I) ~~(we)~~ last saw the deceased alive on 8/27, 1961, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Meadors M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/27/61
22c. PHYSICIAN'S NAME (Type): G. F. Meadors, M.D.
22d. ADDRESS: Damascus, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: Aug. 27 1961
23c. NAME OF CEMETERY OR CREMATORY: Prather
23d. LOCATION (City, town, or county) (State): Prather Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE SEP 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

Item 18 Film 293 8-29-61

1

9404

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09397

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Leamore Dr. Apt D22
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARK — Middle: ANTONIO — Last: WADE
4. DATE OF DEATH: Month: August — Day: 6 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: C.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 27, 1961
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 2 — Days: 10 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Cornelius Wallace Wade
14. MOTHER'S MAIDEN NAME: Izetta Bruce
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: C. Wallace Wade (father) — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO
492 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute bronchitis — 2 wks.
DUE TO
(c) Possible virus pneumonia infection — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
(supplemental pathological report may be sent later)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: o. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 25, 1961, to Aug. 3, 1961, that (I) (we) last saw the deceased alive on Aug. 3, 1961, and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Katharine A. Chapman, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 7 1961
22c. PHYSICIAN'S NAME (Type): 3924 Bath Rd.
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/9/61
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park
23d. LOCATION (City, town, or county) (State): Rockville, Md
24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville Md
25a. REC'D BY REGISTRAR: DATE AUG 11 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9405

CERTIFICATE OF DEATH

09398

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5202 Worthington Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Bethesda
d. STREET ADDRESS: 5202 Worthington Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur; Middle: J; Last: Wadsworth

4. DATE OF DEATH: Month: August; Day: 21; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/8/67
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Editor
10b. KIND OF BUSINESS OR INDUSTRY: office Gov't Printing
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alvin Wadsworth
14. MOTHER'S MAIDEN NAME: (Unknown) Sherman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert L. Wadsworth-son-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS & MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 16 DAYS
420.1
DUE TO
(b) ARTERIOSCLEROSIS, GENERALIZED — 15 YEARS
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from AUG. 3, 1961, to AUG. 21, 1961 that (I) (we) last saw the deceased alive on AUG. 17, 1961, and that death occurred at 8 AM, from the causes and on the date stated above.

22a. SIGNATURE: Philip R. James M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/21/61
22c. PHYSICIAN'S NAME (Type): Philip R. James
22d. ADDRESS: Washington Clinic, Washington D. C

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/23/61
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9406

CERTIFICATE OF DEATH

09399

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda, (Rural)
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5802 Winner Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3V01-4

3. NAME OF DECEASED (Type or print): First: Sharon — Middle: Diane — Last: WALKER

4. DATE OF DEATH: Month: August — Day: 26 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 November 53
9. AGE (In years last birthday): 7 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Walter WALKER
14. MOTHER'S MAIDEN NAME: Bettye Jean MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT: (M) Mrs Bettye J. GAVIN — Address: same as #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Staphylococal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2½ Months
587.3
DUE TO
(b) Fibrocystic Disease — 3 Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 8-1- 1961 to 8-26 19 61 that ☒ (we) last saw the deceased alive on 8-26- 19 61 and that death occured at 2:30AM from the causes and on the date stated above.

22a. SIGNATURE: M.C. O'Bannon M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ M
22b. DATE SIGNED: 8-26-61
22c. PHYSICIAN'S NAME (Type): M. C. O'BANNON, LT MC USN
22d. ADDRESS: U?S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 29 August 1961
23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge
23d. LOCATION (City, town or county) (State): Pikesville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Frank H. NEWELL Funeral Home Pikesville, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 30 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9407

CERTIFICATE OF DEATH

09400

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 10days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fulton 13x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

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073

3. NAME OF DECEASED (Type or print): First: George — Middle: Henry — Last: Walter

4. DATE OF DEATH: Month: August — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 27, 1879

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: George Walter

14. MOTHER'S MAIDEN NAME: Caroline (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pyelonephritis
DUE TO
(b) Nodular hyperplasia of prostate
DUE TO
(c) Arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

2

21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1961 to Aug. 29, 1961, that (I) (we) last saw the deceased alive on Aug. 28 1961, and that death occured at 6:57 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles S. Whitaker, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 29, 1961

22c. PHYSICIAN'S NAME (Type): Charles S. Whitaker, M. D.

22d. ADDRESS: Clarksville, Maryland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/31/61

23c. NAME OF CEMETERY OR CREMATORY: St Pauls Lutheran

23d. LOCATION (City, town or county) (State): Fulton Md

24 FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson — **ADDRESS**: Laurel, Md

25a. REC'D BY REGISTRAR DATE SEP 6 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be related by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9408 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09401

PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): B ethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 701 Ritchie Ave.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Roy — Middle: Eugene — Last: Walter
4. DATE OF DEATH: Month: August — Day: 30 — Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] Separated
8. DATE OF BIRTH: 7.14.31
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance man
10b. KIND OF BUSINESS OR INDUSTRY: Wash. S S C
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Whitney Walker
14. MOTHER'S MAIDEN NAME: Beatrice C. Weaver
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Army
16. SOCIAL SECURITY NO.: 215-24-0145
17. INFORMANT: Whitney Walter 701 Ritchie Ave, Sil. Spring, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suffocation
DUE TO (b): Drowning
DUE TO (c): Syncope from Methane Inhalation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8945

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Overcome by gas in manhole and fell in water
20c. TIME OF INJURY: Hour 10:15 a.m. p.m. — Month, Day, Year: 7/30 1961
20d. INJURY OCCURRED: While at work [X] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street
20f. (City or town): Bethesda — (County): Montg. — (State): Md.

21. I **certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
DATE SIGNED: 8/30/61
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 2. 1961
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetary
22d. LOCATION (City, town, or country): Prince Geo. County — (State): Md.
23. FUNERAL DIRECTOR: J. Arthur Walters — ADDRESS: 254 Carroll St NW. DC
24a. REC'D BY REGISTRAR: DATE SEP 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9409 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09402

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: DOA.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton

d. STREET ADDRESS: 2208 Parker Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer Middle: Mervin Last: Ward.

4. DATE OF DEATH: Month: 8 Day: 27 Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-29-01

9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer,

10b. KIND OF BUSINESS OR INDUSTRY: Nat'l. Academy of Scienc

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Reuben C. Ward

14. MOTHER'S MAIDEN NAME: Lena Markeson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 229-25-7922

17. INFORMANT: Mrs Winona Ward Address: Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: HOURS

420.1

DUE TO (b) MYOCARDIAL FIBROSIS AND INSUFFICIENCY

DUE TO (c) OLD LEFT ANTERIOR DESCENDING CORONARY OCCLUSION,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 8-28-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 30, 1961

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Prince George's County, Md.

23. FUNERAL DIRECTOR: WARNER E. PUMPHREY, INC., SILVER SPRING, MD. ADDRESS: Raymond A. Ziska

24a. REC'D BY REGISTRAR DATE: AUG 30 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed [illegible] death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09403

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington DC
d. STREET ADDRESS: 2318 16th St SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence; Middle: Leslie; Last: Ware

4. DATE OF DEATH: Month: 8; Day: 19; Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-16-02
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mover
10b. KIND OF BUSINESS OR INDUSTRY: Furniture Bus
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm. F. Ware
14. MOTHER'S MAIDEN NAME: Maude Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk
(If yes give war or dates of service): ~~Wrl. War~~
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ruth V Ware — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8-19-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 22, 1961
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or country) (State): Suitland, Md

23. FUNERAL DIRECTOR: Lee Funeral Home — West Pt.
ADDRESS:
24a. REC'D BY REGISTRAR: DATE AUG 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur E. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9411 **CERTIFICATE OF DEATH** 09404

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Clarksburg
d. STREET ADDRESS: Kingsley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Middle: Albert Last: Watkins

4. DATE OF DEATH: Month: August Day: 31 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 12, 1866

9. AGE (In years last birthday): 95 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Brick layer

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Clyde . Watkins

14. MOTHER'S MAIDEN NAME: Mandy Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 7 years

DUE TO (b) Bronchopneumonia, bilateral — 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 10, 1960 to August 31, 1961, that (I) (we) last saw the deceased alive on August 31 1961, and that death occured at 9:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James P. Kerr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/31/61

22c. PHYSICIAN'S NAME (Type): James P. Kerr, M. D.

22d. ADDRESS: Damascus, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-3-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. View

23d. LOCATION (City, town or county) (State): Purdum, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Francis W. Barber

ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9412 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09405

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1217 G ST. SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

099

3. NAME OF DECEASED (Type or print): First: Luther Middle: Ray Last: Weakley
4. DATE OF DEATH: Month: 8 Day: 23 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-23-00
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salvation Army
10b. KIND OF BUSINESS OR INDUSTRY: Truck Driver - Worker
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Weakley
14. MOTHER'S MAIDEN NAME: Ada ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 578-05-8567
17. INFORMANT: Edna M. Weakley Address: 1217 G St, S.E. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 8-23-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Aug 26, 1961
22c. NAME OF CEMETERY OR CREMATORY: Washington National
22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO ADDRESS: 517 11th St S.E. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: AUG 25 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G294 9/11/61 mh

9413

CERTIFICATE OF DEATH

Reg. Dist. No. 10480

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 40 MINS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31510181 FARTHING DR Silver Spring
d. STREET ADDRESS: 3508 Farthing Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Infant Boy Middle: Wermter Last:
4. DATE OF DEATH: Month: Aug Day: 30 Year: 1961
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 30, 1961
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 1 Min.: 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Raymond Wermter
14. MOTHER'S MAIDEN NAME: Adelaide Blake
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia
770.5
DUE TO (b) Atelectasis
DUE TO (c) Prematurity Erythroblastosis Fetalis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Michael J. Buckley M.D.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-1-61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
22d. LOCATION (City, town, or county) (State): Arlington VA

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon
ADDRESS: 3851 - Ga. Ave
24a. REC'D BY REGISTRAR DATE SEP 7 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2074314XV4

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed [illegible] death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9414 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09406

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 447 Southampton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert; Middle: Claude; Last: Whitlock
4. DATE OF DEATH: Month: August; Day: 27; Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 15, 1891
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Roanoke, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Whitlock
14. MOTHER'S MAIDEN NAME: Fisher.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: wife — Address: 447 Southampton Drive.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous coronary disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Bruschart M.D.
EXAMINER'S NAME (Type): FRANK J. BRUSCHART
Address (Street, city, town, or county):
DATE SIGNED: 8-27-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-30-61
22c. NAME OF CEMETERY OR CREMATORY: WASHINGTON NATIONAL
22d. LOCATION (City, town, or country) (State): SUITLAND MD
23. FUNERAL DIRECTOR: W W CHAMBERS & CO — ADDRESS: RIVERDALE MD
24a. REC'D BY REGISTRAR — DATE: AUG 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Young

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9415

CERTIFICATE OF DEATH

Reg. Dist. No. 09407

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11,710 Georgia Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11710 Georgia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha Middle: CROSSAN Last: Willard

4. DATE OF DEATH: Month: Aug Day: 23 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb 21 1884

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Cumming Halliday

14. MOTHER'S MAIDEN NAME: M.S. Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Margaret ~~Mrs~~ Hahn Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b) Hypertensive Heart Disease — Years
DUE TO
(c) Arteriosclerosis - Senility

443 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 29 1960, to Aug 23 1961, that I last saw the deceased alive on Aug 23, 1961, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E. Jones M.D. ADDRESS (Street, city or town, state): 918 Ellsworth Drive DATE SIGNED:

PHYSICIAN'S NAME (Type): Philip E. Jones Silver Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/28/61

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Prince Georges County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A Zska. ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.

24a. REC'D BY REGISTRAR DATE: AUG 25 61

24b. REGISTRAR'S SIGNATURE: Arthur J. Mura

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9415 **CERTIFICATE OF DEATH** 09408

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: Since 1952
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 11,812 Valleywood Drive ~~not in hospital~~

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Wheaton
d. STREET ADDRESS: 11812 Valleywood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard Middle: Henry Last: Wilson

4. DATE OF DEATH Month: Aug. Day: 9 Year: 1961

5. SEX: M **6. COLOR OR RACE:** W **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 14, 1884

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Printer

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Wilson

14. MOTHER'S MAIDEN NAME: Helena Marbel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: William H. Wilson Address: 11510 Maplewood Dr. S.S., Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 weeks
331X
DUE TO (b): Arteriosclerosis, General — 6 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1955 to Aug. 8, 1961, that (I) (we) last saw the deceased alive on Aug. 8 1961, and that death occured at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John C. K. Yu M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug. 9, 1961

22c. PHYSICIAN'S NAME (Type): John C. Yu

22d. ADDRESS: 4912 Adrian St., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/12/61

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City, town or county) (State): Montgomery Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond F. Lisma ADDRESS: Silver Spring, Maryland
Warner E. Pumphrey, Inc. 8434 Georgia Avenue

25a. REC'D BY REGISTRAR DATE AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9417

CERTIFICATE OF DEATH

09409

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wheaton Nursing Home 11901 Georgia Ave. S.S.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5021 Bradley Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

48

3. NAME OF DECEASED (Type or print): First: Nell; Middle: N.; Last: Wilson

4. DATE OF DEATH: Month: 8; Day: 10; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 16, 1886
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Chattanooga, Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles T. Neal
14. MOTHER'S MAIDEN NAME: Emma Bepue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Thomas Wilson-son- Address: 5315 Edgemoor La Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accidents + — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO (b) Coronary heart disease due to — weeks
DUE TO (c) Generalized arteriosclerosis — yrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-7-, 1961, to 8-10-, 1961, that (I) (we) last saw the deceased alive on 8-10- 1961, and that death occured at 4:40 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Charles R Shultz, MD. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-10-61
22c. PHYSICIAN'S NAME (Type): Dr. Charles Shultz
22d. ADDRESS: Simpsinville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/12/61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Frederick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Anthony S. Krans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9418

CERTIFICATE OF DEATH

09410

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs, Md
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alethia Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, Md.
d. STREET ADDRESS: 7006 Wake Forest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1671-2

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: Latimer — Last: Wilson
4. DATE OF DEATH: Month: August — Day: 12, — Year: 19 61-

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 12, 1875
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W Latimer
14. MOTHER'S MAIDEN NAME: Eleanor Sheffield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Ralph Hodgson — Address: College Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure
DUE TO (b): Arterio-sclerotic cardio-
DUE TO (c): vascular lesions

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 19__, to Aug 19 61, that (I) (we) last saw the deceased alive on Aug 3 19 61, and that death accurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: W L Etienne — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-12-61
22c. PHYSICIAN'S NAME (Type): W.L. ETIENNE
22d. ADDRESS: 4713 Baltimore Old College Pk Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 15, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Chicago Illinois

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 15 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9419 **CERTIFICATE OF DEATH** 09411

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 55 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Virginia
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillsville
d. STREET ADDRESS: Route # 4
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roger; Middle: Marion; Last: Worrell
4. DATE OF DEATH: Month: August; Day: 13; Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 19, 1940
9. AGE (In years last birthday): 20 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Blaine Worrell
14. MOTHER'S MAIDEN NAME: Thelma Dee Edwards
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1960 - 1961
16. SOCIAL SECURITY NO.: 229-50-9794
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Staphylococcal cellulitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Nephrotic syndrome — 11 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

591 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from June 19, 19 61 to August 13, 19 61, that ☐ (we) last saw the deceased alive on August 13, 19 61, and that death occured at 6:40PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/14/61
22c. PHYSICIAN'S NAME (Type): Richard Adler, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL, (Specify): Burial
23b. DATE THEREOF: 8/14/61
23c. NAME OF CEMETERY OR CREMATORY: Mona Vista Mem. Gardens
23d. LOCATION (City, town or county) (State): Carroll Count, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 18 '61
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MA[illegible] DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9420 — 09412

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 41 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
d. STREET ADDRESS: RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth — Middle: Felicia — Last: Zebuhr
4. DATE OF DEATH: Month: August — Day: 26 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 6, 1927
9. AGE (In years last birthday): 34 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Harry Tyson Bussard
14. MOTHER'S MAIDEN NAME: Mary Catherine Lawson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Medical Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Melanoma (Generalized) 1909
~~DUE TO~~ (b): Metastasis to lungs, liver, ~~and~~ lymphnodes
~~DUE TO~~ (c): and both breasts.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 9, 1960 to Aug. 26, 1961, that (I) (we) last saw the deceased alive on Aug. 25 1961, and that death occured at 10:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 26 1961
22c. PHYSICIAN'S NAME (Type): Jack Schumacher
22d. ADDRESS: Gaithersburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-29-61
23c. NAME OF CEMETERY OR CREMATORY: St, Rose
23d. LOCATION (City, town or county) (State): Gaithersburg. RFD Clopper. Md.
24 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. Gaithersburg. Md. — ADDRESS:
25a. REC'D BY REGISTRAR: DATE AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with State Dept. of Health prior to burial, cremation, or removal, and if event, within 72 hours after death.

VR A15 (4)
15M 9/60

Relinquishment Agreement (Easement)
— Maintaining bump, drying and lightstation
and bath house.